B.K.S

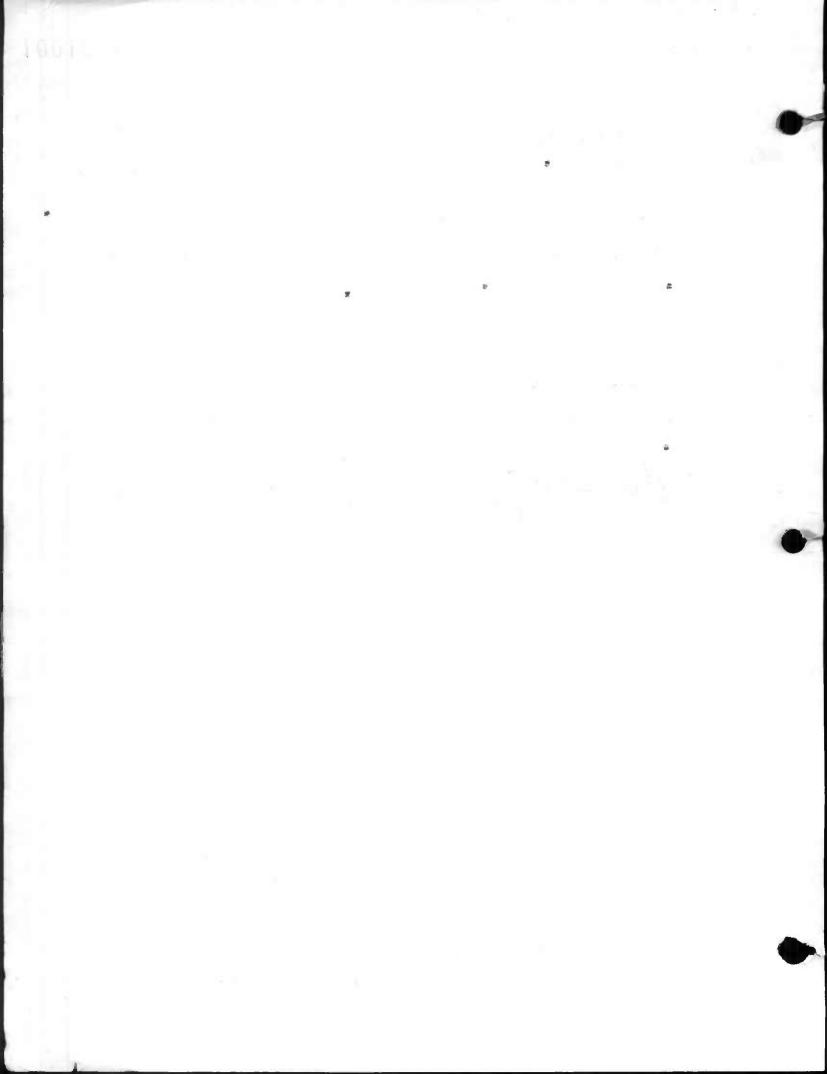
JOHN ALLEN COMBS JR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

21001

	Items:23	a p	art I,27,28a-f per MEO	G-749 7/23/97 dh	Cer	tificate of	Death		Reg. No.		
	Physic	an	1. Decedent's Name (First, Middle, Les	•				2. Date of D	eath	Year	3. Time of Death
d	/Medi	cal	John Allen Combs				4 0: 7	JUNE		9 <sup>v</sup> 9 <sup>a</sup> 7	0718 AM
Ĕ.	Examir	ier	4a. Facility Name (If not institution, give NAVAL AIR STAT	TION			PATUXE	NT RIV	ER ST.	of Death MARY	'S
	Funeral Director		5. Social Security Number 217–49–8150 1  Usual Residence of Decedent	ex 7. Age (In yrs. le	est birthday) Yrs.	Months Days				9. Birthpla Count Maryl	ace (Stete or Foreign try) and
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation				10	Od. Inside City Limits
	e Mar	Director	Maryland St. Mar	ry's Le	exingto	on Park					1 ☐ Yes 2 ■ No
	with th		10e. Street and Number			10f. Zip Code		,	10g. Citizen of \	What Count	ry?
	Jeath The 23	Funeral	21272 Lexwood Cot	12. Was Decedent Ever in U.S	S. 13. V	20653 Vas Decedent of	Hispanic Origin?	(Specify Yes or N	United	d Stat	
Maryland 21215-0020	2 should be filed within 72 hours efter death with the Maryland end Mental Hygians. Is marked other than "natural", or items 23a or 28a-f show currentic event, the Medical Examine Trust by notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates:		Yes, specify Cul	Hispanic Origin? pan, Mexican, Pue Specify:	èrto Rican, etc.)	Specify	ck, White, e y: Whi	
15-0	"natu	etec	15. Decedent's Ed (Specify only highest gre		16a. Deced (Give	ent's Usual Occu	pation during most of w	rorking	16b. Kind of B		
212	withir iana.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	N / A	9d)		N/A		
pu	al Hyg other	Be C	17. Father's Name (First, Middle, Last)			N/A	18. Mother's N	ame (First, Middle	e, Maiden Sumen	ne)	
yla	l Ment I Ment Inrked	Tol	John Allen Combs,					nn Jenki			
>	C1 00 m m		19a. Informant's Name/Relationship (7)  John Allen Combs.	**					ber, City or Town, on Park		*
re,	is 1 and of Haalth Item 27 other tr		20a. Method of Disposition	20b. Pla	ace of Dispos	sition (Name of netory or other ple		Date	20c. Location -		
E	Pages ment of ant: If its ury or o		1 ■ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Hemoval from State			•	6/16/97	Leonardt	town,	Maryland
Baltimore,	permit. Pag Department Important: I any Injury o		Thetule of Funeral 9/32	ent	22. Br	Name and Addr	ess of Facility Funeral	Home, F	P.A.		
	20200			nkenship	229	955 Holl	ywood Ro	ad, Leor	nardtown		20650
	Physician	6 9	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	one cause of each line.	. Do not ente	er the mode of dy	ing, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition	IDIOPATHIC PU	LMONARY	HEMORRHAG	iE				
	Examiner	7	resulting in deeth)	a	es a consequ		<u> </u>	-			
T	uted d ansit	Examiner	Segmentially that are divises	b. Due to (or	as a consequ	ionas efti					
Ć,	a axec ian an uniel-tr		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	derice or):					
68/60,	cate b physic the b	edical	thet initiated events resulting in death) Last	c. Due to (or	as a consequ	ience of):					
×	The law requiras that the death certificate ba axecuted to has been signed by the attending physician and page 2 should be detached for use as the bunet-transit	2	L.	d							
. Bo	daath le atte ed for	Physician/	Part II. Other significant conditions co	ntributing to death but not resul	tina In the un	derlving cause gi	ven in Part I.	23b. Dio	I tobacco use co	ntribute to	the cause of death?
r Ö	d by the	Phy				,			Yes 2⊠ No		ably 4 ☐ Unknown
ds,	signe ld be c	d by						240 Wa	a an autonou	24h Wai	re autopsy findings
Hecords,	w require been si should	Completed						perl	s an autopsy formed?	avai	ilable prior to
He	The law ate has page 2	mo.						1 🗵	Yes 2□No		Yes 2□ No
VItal	ysician: The s certificate director, pag	Be	25. Was case referred to medical examiner?  A Yes 2 □ No	11				eath (Check only	one)	,	
5	Phys this ral di	To	XQXYes 2□ No 27. Manner of Death		R/Outpatient 28b. Time of	3LI DOA			how injury occur		
lon	nding l ath. r: Aftar na funar	atlor	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Injury: 33 four	Wo	ork? ]Yes 2∭NNo	unknown	,,		
DIVISION	or Attending P after death. I Director: After of In by the funer	ertification:	3 ☐ Suicide	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre			28f. Location City or To	(Street and Numb	er or Rural Lexwood	Route Number,
ם	pital ours a eral D	O	29a. Certifier 1 ☐ Certifying Phy	found at home	ladge death	a a surred at the st		Park, Md			
	To the Hospital or Attending within 24 hours aftar death.  To the Funeral Director: Aftar completely filled in by the fune	edical		rsician: To the best of my know Iner: On the basis of examination and manner stated.	on and/or inve	estigation, in my	opinion, death occ	curred at the time	, date and place,	and due to t	the cause(s)
	Withir To th	×	29b. Signature and title of certifier	1	1	29c. Licen			29d. Date signe		
			Atysh.	h Vlac	UT, N	10	C.M.E		JUNE	12,	1997
			30. Name and eddress of person who c				ot Dal	timoro	, Maryl	and	21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu		m stre	er, Dal	гтиоте	, Mary	.anu	21201
	Registr	ar	JUN 17 19	397 Juli Davide	or Rords	Щ					
DHI	MH 16 Rev 6/95			U							



#### Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Physician Month 1997 June 30, Martin Gerald Cowley 3:00 pm /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e. Fecility Neme (If not institution, give street and number) Examiner 6202 Twin Point Cove Road Cambridge Dorchester If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Dev. Year) Aug. 19, 1925 6. Sex 14 M 2 □ F 5. Sociel Security Number 9. Birthplece (State or Foreign Country)
Ireland 7. Age (In yrs. last birthdey) Funerai Yrs. 168-30-1308 71 Director Usual Residence of Deceden the Marylend 10e. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Maryland Dorchester Director Cambridge 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? deeth with 6202 Twin Point Cove Road 21613 Irish-American 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: à 3 Widowed 4 □ Divorced Specify White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 end 2 should be filed within Department of Heelih end Mentel Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event. The Market in the Elementery/Secondary (0-12) College (1-4or 5+) Insurance Agent Insurance 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Jeremiah Cowley Kathleen Clarke 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Judith Piccari - Niece 3016 Bedminister Rd., Perkasie, PA 18944 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Hillside Cemetery 7-7-97 Abington, PA 21. Signature of Funeral Serv 22. Neme end Address of Fecility That caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, Approximate to the death. Approximete Intervel Between Onset end Death **Physician** corcinona of unknown pro /Medical Immediate Ceuse (Finel 2 years disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner physician end s the buriel-transit certificete be axecuted Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): signed by the at d be dateched for Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert f. 23b. Did tobecco use contribute to the cause of death? 3 □ Probably JUnknown 1 Tyes 2 No 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en europsy certificate hes 2 DINO 1 Tes 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: within 24 hours efter death.

To the Funeral Director: After this certifics completaly filled in by the funeral director, i Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Deeth Certification: 28a. Date of Injury (Month, Dev Year) 28b. Time of 28c. Injury ef Work? 28d. Describe how Injury occurred 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Phyelcien: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and menner stated. Medical 29a, Certifier (Check only one) 29b. Signature and fitter of ceptifier 29c. License number 29d. Dete signed (Month, Dey, Yeer) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

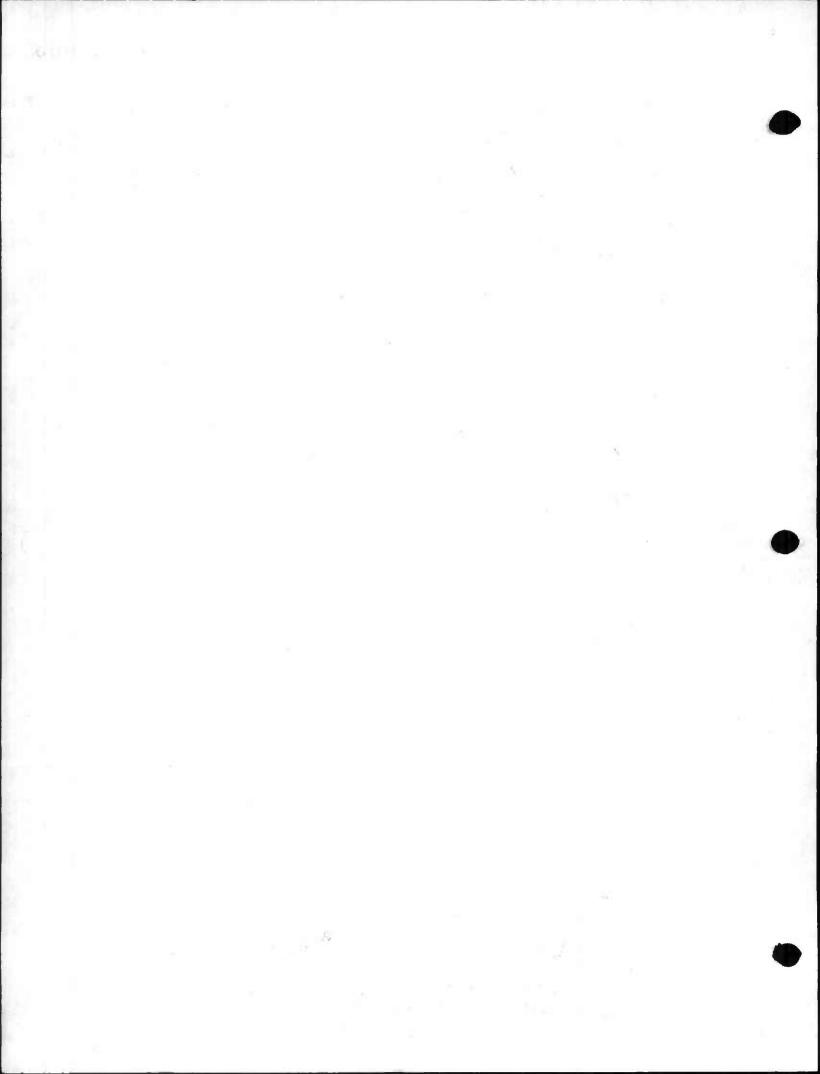
Devid 6 0/12 m m 503 Dutchmans Line Easton m 2160/ 31. Date filed (Month, Day, Year) 32. Begistrer's Signeture State This Davolson Rardall

Registrar

JUL 3

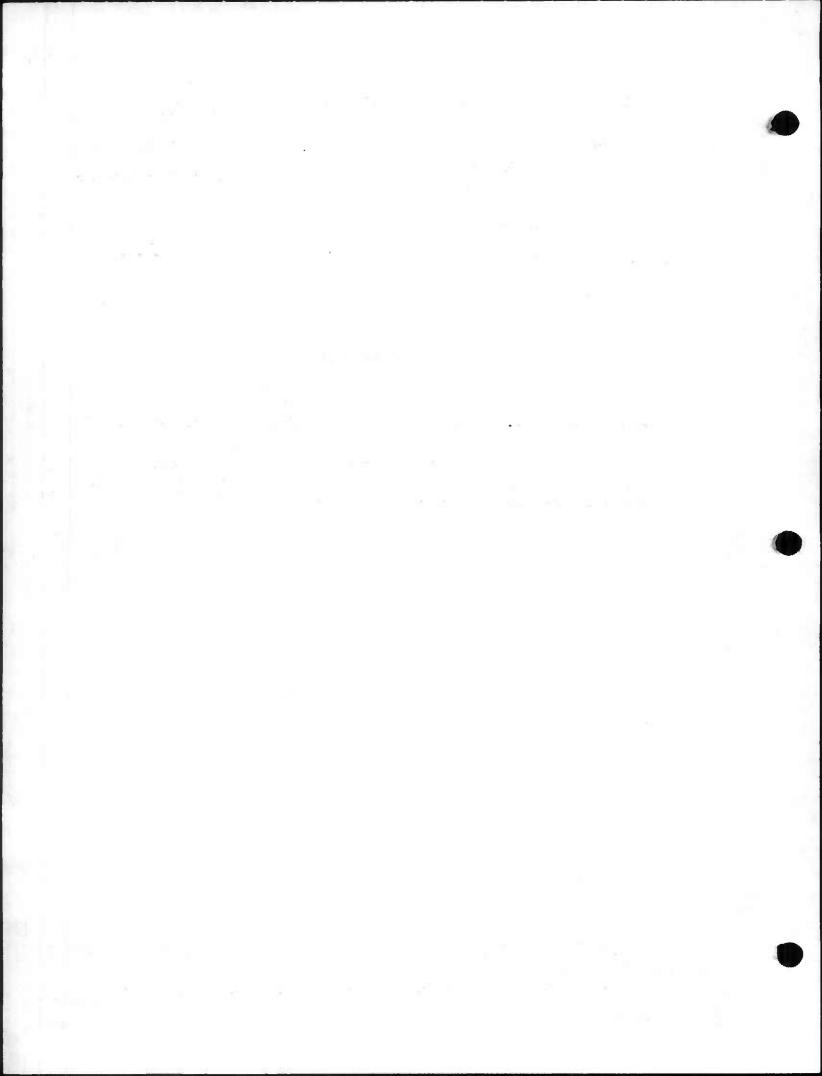
### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 0 0 3

				Ce	rtificate o	f Death	R	leg. No.						
		1. Decedant's Nama (First, Middla, L	ast)				2. Data of Daa	ith		3. Tima of Death				
Physic /Modi		Mildred Mol	perly Culi	ler			June	23,	1997	2:03 pm				
/Medi Examir		4a. Facility Nama (If not institution, g.	- 4			4b. City, Town, or	Location of Daath							
		Longview N	ursing Home	2		Manche	ster		roll					
Funeral				yrs. last birthday	If Undar 1 Yes	ar If Under 24 Hr				aca (Stata or Foraign				
Director		214-14-5288 Usual Rasidence of Dacedant	1□ M 2 F 8		Months Day	rs Hours Mir	10/26	/14	Count U . S	(y) A.				
/lend		10a. State 10b. County	10	c. City, Town or L	ocation				10	d. Insida City Limits				
with the Marylend s or 28a-f show be notified at	ector	MD Baltin	more	Parkvi						1 ☐ Yas 2 No				
23s or	Funeral Director	8800 Walther	Blvd.		10f. Zip Code 2123		1	U.S		ry?				
If a within 72 hours effer death with the Maryland Hygiane. Hygiane they than "natural", or items 23s or 28s-f show int, the Medical Examiner must be notified at	by Fune	11. Marital Status  1 □ Navar Marriad 2 □ Marriad  3 ◯ Widowad 4 □ Divorced	12. Was Decedant Eval Armed Forcas? 1  Yas 2 No If Yas, Give Yaar or Datas:	r in U,S. 13.	Was Decedant of If Yas, specify Cu	f Hispanic Orlgln? (i uban, Maxican, Pua o <i>Spacify:</i>	Specify Yas or No- rto Rican, atc.)		ce - America ick, Whita, a fy: Whí	itc.				
"netural"	Б	15. Decedent's E		16a, Deca	dent's Usuai Occ	unation		16b. Kind of B						
d within 72 grane. r than "ns	Completed	(Spacify only highest gi	rada com <i>plated)</i> College (1-4or 5+)	(Give	kind of work dor DO NOT use reti	a during most of we	orking	TOD. TURN OF D	doning of more	200 y				
se filed withing Hygiane.	Be Co	17. Fathar's Nama (First, Middle, Las	t)	Adm	itting	clerk 18. Mother's Na	ıme (First, Middle, I	HOSPI Maiden Surnan	tal ma)					
s 1 and 2 should be filed if Health and Mantel Hyg Item 27 is marked other other traumatic event,	To	Earl J. Mober 19a. Informant's Nama/Ralationship		19h Maili	ing Address /Stre	Vera Matand Numbar or F	L. Cann	r City or Town	State 7in	Code)				
d 2 signal of the traus		Barbara Thomps												
Haa Haa Haa		20a. Mathod of Disposition		Ob. Place of Disp		cbrook R		20c. Location						
permit. Peges 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.		1 ☐ Burial 2 Cramation 3 [	Ramoval from Stata	cametery, cra	matory or other p		6/21/97		,	•				
Departiment Departiment Important Important Incorporation		Carroll Cremation, Inc. Hampstead, MD  1. Signatura of Funaral Service Licensee  22. Nama and Address of Facility  Eline Funeral Home  934 S. Main St.  Hampstead, MD 210												
_		23a. Part1. Entar the disaasa, or con shock, or heart failura. List only	nplications that caused tha	~			нат	pstead ast,	d, MD	21074 Approximata Intarval Batwaen				
Physician										Onsat and Death				
/Medical Examiner		Immadiata Causa (Final disaasa or condition		Ci	IA					2 Albary 3				
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p #	in in		h											
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E 0 6	/Medical	rasulting In death) Last	d											
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tha d y tha ched	ys	Part ii. Other significant conditions	contributing to death but no	t rasulting in tha u	indarlying ceusa (	givan In Part I.	23b. Did to	bacco usa co	ntribute to t	the cause of death?				
signed by th	by Pr						1 🗆 Y	ee 2⊟No	3 Proba	ably 4 ☐ Unknown				
been been shoul	Completed						24a. Was a perform	n autopsy ned?	avail	a autopsy findings lable prior to iplation of ceuse eath?				
ician: Tha law requires the certificate hes been signe ractor, pege 2 should be o	5						1 □ Y€	s 2010	10	Yas 20 No				
ysician: s cartifica diractor,	Be	25. Was cesa refarred to madical				26. Placa of De	ath (Check only on	a)						
S 00	o L	examinar?	Hospital:	2 ☐ ER/Outpatier	nt 3 DOA	ther: 4 Nursing I	Homa 5□ Rasida	ince 6 □Oth	ar (Specify)					
		27. Mannar of Daath	28a. Data of Injury (Month, Day Yea	28b. Time o			28d. Dascribe ho							
Attending in death.	atle	1 ☐ Natural 5 ☐ Panding 2 ☐ Accidant Investigation		ar) Injury		∃Yas 2⊟No								
	Certification:	3 ☐ Suicida 6 ☐ Could not b 4 ☐ Homicida datarminad		Э	28f. Location (St. City or Town	reet and Numb n, Stata)	per or Rural I	Routa Numbar,						
To the Hospital or within 24 hours afte To the Funeral Dir completaly filled in	edical	29a. Certifiar 1☐ Certifying Pt (Check only one) 1☐ Medical Example 1	nyaician: To the bast of my ninar: On the basis of exer and manner stated.	knowledga, daath mination and/or in	n occurrad at that vastigation, in my	tima, data and place opinion, daath occi	e, and due to tha ca arred at the tima, da	ausa(s) and ma ata and place,	annar as stat and dua to t	ted. ha causa(s)				
ithin o the	-	29b. Signature and titla of certification	and manner stated.		29c. Licar	nsa number	20	9d. Date signe	d (Month D	av Veer!				
F 3 F 8		1	141 =1		Co. Elodi	7771. ~	_   "	1 1 -	. / C	.y, 10ai/				
	-	, V	000			531007		0/2	ylar					
		30. Nama and address of person who	complated ceuse of daath			1 10	4							
		Od Date Stad St S. D.	) teven Utalto		Mararu	Kita Na	Lest 2 day	ns s	irry					
Stat	e	31. Data filed (Month, Day, Year)	1007 32 Plan strant S	ignatura	-11									



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 2 1 0 0 4

						Certif	ficate of	Death		Reg. No.		
	Physic		Decedant's Name (First, Middle, La Shirley		chals		Chaille		2. Date of Dea Month June 2	ath Day	Year	3. Time of Death 3:30pr
1	/Medi Exami		4a. Facility Name (If not institution, give	re street and number)				4b. City, Town, or L				
	EAGIII		6108 Arbroath Dr:	ive				Clinto	on			orge's
	Funeral Director		5. Social Security Number 6. S 405–26–1516 Usual Residence of Decedent		ge (In yrs. last b		Under 1 Yaar lonths Days	If Under 24 Hrs.		h /, Year)	9. Birthp	place (State or Foreign
	laryland show	7.	10a. State 10b. County		10c. City, Tov		on				1	10d. Insida City Limits
	with the M a or 28a-f	Director	Maryland Prince (	,	Clin		10f. Zip Code 20735			10g. Citizen of V		1 ☐ Yes 2 🔀 No
	eath re 23	era	6108 Arbroath Dri	12. Was Dacadent	Ever in 11 S	13 Was		Hispanic Orlgin? (Sp	acifu Vac or No			en Indian,
Maryland 21215-0020	within 72 hours after death with the Maryland ana. than "natural", or itams 23a or 28a-f show ha Medical Examinat mark be indiffed at	by Funeral	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forcas?  1 ☐ Yes 2 X  If Yes, Giva  Year or Dates:		If Ye	Yes 2 No	an, Mexican, Puerto	Rican, atc.)		ck, White,	
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra	ducation	168	. Decedent	's Usual Occu	pation during most of work	king	16b. Kind of B	usiness/Inc	dustry
21	within ana. than "	Completed	Elementary/Secondary (0-12)	College (1-4or !	5+)	life. DO	NOT use retire	d)	\ing			
7	be filed withintal Hygiana.	ဒိ	12th	N/A		Но	memake			Hon		
and	ntal F od ott	Be	17. Father's Name (First, Middle, Last,					18. Mother's Nam			10)	
Z	should b ind Menta marked	5	Adam Michal  19a. Informant's Name/Relationship (			C. Address in	44	Charlot		Worden	TAULT IN	
Ma	trau		James R. Chaillet	,, ,	sband)	_		and Numberor Ru Ath Drive				,
re,	ges 1 and 2 should t of Haalth and Mer if Item 27 Is marke or other traumatic		20a. Method of Disposition	. (2200			on (Name of ory or other pla			20c. Location -		
Baltimore,	rtmer rtant: njury		1∑ Burlal 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	y)		recti	on Ceme	etery	1997	Clint	on, l	Maryland
Ba	Depa Impo any I		21. Signature of Funeral Service Licer	Belo	nger		ama and Address		ee Funer a Ferry			C. MD 20735
	Physician		23a. Part1. Entar the disease, or com shock, or heart failure. List only	plications that caused ona cause on each li	death. Do	not enter th	na mode of dyl	ng, such as cerdiac	or respiratory ar	rest,	.	Approximate Interval Between Onset and Death
	/Medicai		Immediate Cause (Final disaase or condition	CA	WER	0	= VH	E PAL	ICASA	9	i	MONTHS
	Examiner		resulting in death)	a	Due to (or as a			C 12/	4.21	۷	- 14	, ,,,,,,,,
	D #	iner			(1)	. District	31,00					
o,	axecute an and rial-trans	Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):  Due to (or as a consequence of):									
ox 68760,	The law requires that the death certificate be axecuted the has been signed by the attending physician and page 2 should be detached for use as the bunal-transit	resulting in death) Last										
O. Bo	es that the death or igned by the attend be detached for us	Physician/	Part II. Other significant conditions of	ontributing to death be	ut not resulting	n tha under	tylng causa gi	ven In Part I.	23b. Did t	obacco use co	ntribute to	the cause of death?
s, P.O	ss that t gned by be detail	by Ph	RECENT	CERS	BUUVA	SCU	LAR	ACCI08	WT 10	es 2 No	3 Prot	bably 4 🗍 Unknown
Division of Vital Records,	a law require has been si je 2 should l	Completed							24a. Was a perfor		ava	are autopsy findings ailabla prior to mpletion of ceuse death?
<u> </u>	ystclan: The I is certificate he director, page	ОП							1□ Y	es 2 No	10	Yes 2□ No
/ita	certificate rector, pag	Be	25. Was case referred to medical examiner?					26. Place of Deat	th (Check only or	ne)		
5	hysic his co	2	1 ¥ Yes 2 □ No	Hospital: 1 ☐ Inpatie	nt 2 ER/O	utpatient 3	L DOA		ome 5 Resid	ence 6 Oth	er (Specif)	y)
Lois	i or Attanding Physiolan: aftar death. Director: Atter this certific i in by the funeral director,	Certification:	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation			Time of Injury	28c. Inju Wo M 1 □	ry at rk? Yes 2 □ No	28d. Describe h	ow injury occur	red	
DIX	5 # E C	Sertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubuilding, etc	ury - At home, fa c. (Specify)	arm, street,	factory, office		28f. Location (S City or Tow		er or Rura	I Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai (	29a. Certifier (Check only one)	ysician: To the best of liner: On the basis of and manner sta	examination ar	e, death occ nd/or investi	curred at the ti gation, in my o	me, date and place, opinion, death occur	and due to the o	ause(s) and ma ate and place,	nner as st and due to	ated. the cause(s)
	To the Vithir	Me	29b. Signatura and title of certifier				29c. Licans	se number	2	9d. Data signed	d (Month, i	Day, Yaar)
		-	MIX	Zest			D-	18545		TUNE	30	1997
			30. Name and address of person who o	completed cause of de	eath (Item 23a)	(Type, Prin		00 0		10106		(1)
			Philip Wisots					e. # 700	Waldorf	MD 206	<b>n</b> 2	
	Sta	te	31. Data filad (Month, Day, Year)							- ZUO	UZ	
	Registr	ar	6/30/97		JUL 0 2	1997	Stuly	Davidson	ardall			



Please Type or Print in I State of Marylan	Black Indelible In nd / Department of		-	_	ble-7	21005
	Certificate o	f Death	Rec	g. No.		
1. Decedent's Neme (First, Middle, Last)			2. Date of Deeth			Time of Death
Nicholas G. Charuhas			June	Dey 16, 19	Year 97 9:	45 P.M.
4e. Fecility Neme (If not institution, give street end number)		4b. City, Town, or L		4c. County		
Anne Arundel Medical Center		Annapolis	3	Anne	Arunde1	
5. Social Security Number 6. Sex 7. Age ( <i>In yrs.</i> 578 22 3000 12 x 2 □ F 7. Age ( <i>In yrs.</i> 71	Yrs. If Under 1 Yes Months Deg		8. Date of Birth (Month, Dey, May 31,	Year) 1926	9. Birthplace ( Country) Maryla	(Stete or Foreign nd
34	ty, Town or Location					nside City Limits
	ambrills					☐ Yes 2万No
10e. Street end Number	10f. Zip Code		10	g. Citizen of	What Country?	
2011 Hunt Cliff Drive	2105	•			States	
11. Marital Stetus  1 □ Never Merried 2▼Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U Armed Forces?  X⊠ Yes 2 □ No If Yes, Give Year or Detes: WWTT	If Yes, specify C	of Hispenic Origin? (Spuban, Mexican, Puerlo No Specify:	pecify Yes or No- p Rican, etc.)		ce-American in ck, White, etc.  White	
100.0.000. 11111						
15. Decedent's Education (Specify only highest grede completed)  Elementary/Secondary (0-12) 1 2 College (1-4or 5+)	16e. Decedent's Usuel Occ (Give kind of work dor life. DO NOT use ret	ne during most of worl ired)	king		usiness/industry aurant	'
17. Fether's Neme (First, Middle, Last)	0 1111		o (First Middle 14			
Gust Charuhas			ne (First, Middle, Mi			
19e. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Stre	Evange1			olson	
XX Burial 2 Cremetion 3 Remove from State	2011 Hunt C1 Plece of Disposition (Neme of pemeter), cremetory or other pryland Veterar  22. Name and Add Robert E.	ns Cemeter	Date 20 y 6/19/97	Crow	City or Town, S	
Immediate Ceuse (Final disease or condition resulting in deeth)  Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated exercises.	or es e consequence of):  or es e consequence of):  or es e consequence of):	Pola Forta	ire		Inter	vel Between et end Death
Part II. Other elanificant conditions contributing to death but not rec	ultime in the condentation of the	airea la Danii	OOL Did to		-4-154-4-4-4-	
Pert II. Other elgnificent conditions contributing to death but not resi	unting in the underlying cause	given in Pen i.	1 \( \text{Yes}	_	3 ☐ Probably	cauee of deeth?
			24a. Was an performe		eveilable	utopsy findings e prior to ion of ceuse ?
			1 ☐ Yes	21 No	1 ☐ Yes	2□ No
25. Was case referred to medical examiner?		26. Plece of Dea	th (Check only one,	)		
Hospital:	ER/Outpetient 3 DOA 28c. In Injury		ome 5 ☐ Residen 28d. Describe how			
2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At he building, etc. (Specification 1)	ome, farm, street, factory, officity)	□ Yes 2 □ No	28f. Location (Stre City or Town,	et end Numb State)	per or Rurel Rou	te Number,
29a. Certifier (Check only one)  12 Certifying Physicien: To the best of my known one)  13 Certifying Physicien: To the best of expendence and menoer stated and menoer stated.	wledge, deeth occurred et the tion end/or investigation, in my	time, dete end plece, y opinion, death occur	end due to the ceu red et the time, dat	ise(s) end me e end place,	enner es steted. and due to the o	cause(s)
29b. Signature and title of certifier	29c, Lice	nse number	Z 290	d. Date signe	d (Month, Dey,	Yeer)
30. Name end eddress of person who completed cause of deeth (Item Henry (anton MD) 2	n 23a) (Type, Print) Red. 1	ant way	F130 an	napol	Is Md.	21401

To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours effect death.

To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be deteched for use as the buriel-transit Division of Vital Records, P.O. Box 68760,

> State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

Be Completed by

P

Funeral

Director

permit. Peges 1 and 2 should be filled within 72 hours efter death with the Meryland Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examination and printed at any injury or other traumatic event, the Medical Examination and printed at approximation.

Physician

/Medical Examiner

Baltimore, Maryland 21215-0020

I facility and the second

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 0 0 6

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Yaar **Physician** 91 Marguerite M. Curreri 2 92 /Medical 6 4a. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's General Hospital Prince George's Cheverly If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
May 2, 1932 5. Sociel Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days 1 M 2CKF Yrs. Director 219 30 0252 65 Maryland Usual Rasidance of Dacedant with the Marylend 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Prince George's Bowie XXYas 2□No Maryland Director 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? ŏ "natural", or items 23a 13322 Idlewild Drive 20715 United States Pages 1 and 2 should be filed within 72 hours after death is net of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23: Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian, 11. Maritel Status Black, White, etc. 1 ☐ Yas 24 TNo If Yas, Giva Yaar or Datas: 1 ☐ Navar Marriad 🔀 Merrled Baltimore, Maryland 21215-0020 1 ☐ Yas ★ No White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decadant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Dacedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Be Charles A. Valenti Henrietta J. Brockschmidt 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Numbar, City or Town, Stata, Zip Coda) permit. Pages 1 and 2:
Department of Health ar
Important: if item 27 is
any injury or other treu John Curreri Husband 13322 Idlewild Drive Bowie Maryland 20715 20a. Mathod of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 20b. Placa of Disposition (Name of cematary, crematory or othar place) 20c. Location - City or Town, Stata 1997 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery June 24, Clinton Maryland 21. Signatura of Fune al Saryina License 22. Name and Addrass of Facility Robert E. Evans Funeral Home, Inc. Pert1. Enter tha disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or haert failura. List only or cause on each line. Approximata Interval Betw Onset end Deeth **Physician** /Medical Immediate Causa (Final cobolisa disaasa or condition resulting in deeth) Examiner Examiner 20 Cerd.h. The lew requires that the death certificate be executed the buriel-transit Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying Cause (Diseesa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of) and P.O. Box 68760, Physician/Medical Due to (or as a consequenca of) 98 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? signed by I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed by 24b. Wara autopsy findings eveilabla prior to complation of ceusa of death? 24a. Was en autopsy parformed? peeu page 2 s 20 No certificate 1 ☐ Yas 2 ☐ No To the Hospital or Attanding Physician: "within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was cesa referred to medicel examiner? Be 26. Pleca of Daeth (Chack only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 No Medical Certification: To 1 Inpatiant 2 □ ER/Outpetient 3 □ DOA 27. Mannar of Daath 28a. Date of Injury (Month, Day Yaar) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 3 ☐ Suicida 6 Could not be 28f. Location (Straat and Number or Rural Routa Numbar, City or Town, Stata) 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) 4 Homicide 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceusa(s) and manner as stated. 29a. Cartifian 2 Medical Examinar: On the basis of axamination end/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) and manner stated. 29b. Signature and time of certifian 29c. Licansa number 29d. Dete signed (Month, Day, Year) 0 30. Name and eddrass of person who complated ceuse of death (Itam 23a) (Typa, Print) 32 OK N. 31. Data filad (Month, Day, Yaar) 32 Registrar's Signatura State JUN 24 1997 Registrar

DHMH 16 Rev 6/95

to reconsiderate to

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

21007

						Ce	rtificate d	of Death	7		Reg. No.		,			
	Physic	ian	Decedent's Name (First, Middle							2. Data of Da		Yaar	3. Time of Death			
U	/Medi		Margaret Alice	Davis						June	16	1997	8:25 PM.			
	Exami		4a. Facility Name (If not institution		ımber)					ocetion of Dee		nty of Deeth				
	0.00		St. Mary's Hosp	ital						town		it. Ma				
	Funeral Director		5. Sociel Security Number 170–36–4185	6. Sex 1 ☐ M 2 ■ F	7. Age (In yrs. 89	last birthday, Yrs.	Months Da	ear If Under ys Hours	Min.	8. Date of Bi (Morgh, D November	<sup>lay</sup> 30, 190	9. Birth	place (State or Foreign intry) ylvania			
	pu .		Usual Residence of Decedent  10a. State 10b. County		10- 0	h. Tour out										
	anyle	-			10c. CI	ty, Town or L							10d. Inside City Limits			
	M 98 4	octo		lary's		Leona	rdtown						1 Tas 2 No			
	d within 72 hours after death with the Maryland jiene. I than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	rai Director	10e. Street and Number 43946 Lanedon I	rive			10f. Zip Cod 206				10g. Citizen d United					
	aep L	Funerai	11. Marital Status	12. Was Dec Armed Fo	edent Ever in U	,S. 13.	Was Decedant	of Hispanic Or	ngin? (Sp	pecify Yas or N	o- 14. R	ace - Amari				
21215-0020	ours after	by	1 Navar Merried 2 Marri 3 Widowed 4 Divorced		2 No		1 ☐ Yes 2 ■ I			rnoan, ato.,	Spec		ite			
5-0	72 honetur	Completed	15. Decedent (Specify only highes	's Education		16a. Dece	dent's Usuei Oc	cupetion	et of wor	l in a	16b. Kind of	Business/In	ndustry			
2	thin .	ple	Elementery/Secondery (0-12)	College (			kind of work do DO NOT use re		St Of WOrl	ong						
	filed within Hygiene. ther than "	00		4		Н	omemake	r			N/A					
D	should be filed of Mentei Hyg marked other metic event,	Be (	17. Fether's Nema (First, Middle, I	Last)				18. Moth	er's Nam	ne (First, Middle	a, <i>Maid</i> an Sum	eme)				
<u>a</u>	Mentei Mentei Brked o	To	George William	Hatcher				Mars	are	t Marth	a Mallo	v				
Maryland			19e. Informent's Neme/Reletions			19b. Melti	ing Address (Str					-	p Code)			
	5 2 5 5		Katherine L. Ha	tcher. Da	aughter	4394	6 Laned	on Driv	ve.	Leonard	town. M	D 206	50			
ē,	es 1 and 2 of Health item 27 it r other tra		20a. Method of Disposition		20b. F	Place of Dispo	osition (Neme of	f	, ,	Dete	20c. Location					
Baltimore,	permit. Peges 1 Department of H Important: if ite any injury or ot once.		21. Signature Funeral Sovice Licenses  22. Name end Address of Feellity  Prince Field Funeral Home P. A.													
g	Depariment Important Irreportant Irreporta		Lloyd Cemetery 6/21/97 Ebensburg, Pennsylvania  21. Signature Funeral Specify)  22. Name and Address of Facility  Prince field Funeral Home. B. A.													
	00 = 4 O		Brinsfield Funeral Home, P.A.  22955 Hollywood Road, Leonardtown, MD 20650  3a. Pert1. Enter the diseesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Intervel Between Intervel Between Onset end Death Onset end Death													
P.			23a. Pert1. Enter the diseesa, or	complications that o	aused the deat	h. Do not en	ter the mode of	dying, such as	cardiac	or respiretory	errest,	11, 110	Approximete			
	Physician	Н	Short, of Hoot foliate. Elect	any one dedde on e	Joor Mile.		53						Intervel Between Onset end Death			
ħ.	/Medical		Immediate Cause (Finel	1	*	1	0 6	- 0	0			ì	146			
	Examiner	disaase or condition										- 1	Tare			
		ner	Due to (or as e consequence of):  Sequentially list conditions, if eny, leeding to immediate cells. Enter Indentional conditions and the conditions of the c										- 1	11		
	uted	늍	On a Control of the C	b	Zu O	Leps	1	ver 1	~00	In	eum		Inn			
<u>,</u>	eath certificate be executed ettending physician end for use es the buriel-transit	Exa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury													
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9	phy s the	Medicai	resulting in deeth) Lest		Due to (o	r es e consec	quance of):					1				
K	ding se e	Ž	1	d												
0	etten for u	Physician/														
j.	the d	ysi	Pert II. Other algnificent condition				inderlying causa	given in Part	l.	23b. Did	tobacco usa	ontribute to	o the cause of death?			
L	- D -	윤	Consister	Heart 1	Farly	ne -				1 🗆	Yes 2 No	3 □ Pro	bably 4 Unknow			
Records,	8 6 8	þ														
5	v requires been sign should be	Completed	Congester De	nentes							s an autopsy ormed?	av	era autopsy findings eileble prior to			
ပ်	BW Is b	ple	June .										omplation of ceuse death?			
Ľ	0 5 0	omo								10	Yes 2000	11	□Yas 2 No.			
VII	iclan: The certificate rector, peg	Be C	25. Wes case referred to medical					26 Place	a of Doo	th (Check only						
>		To B	axaminer?	Hospitel:	Inpatient 2	ER/Outpetler	nt 3 DOA	Other:		oma 5 ☐ Res		When /Cassi	4.1			
0	Phys rthis aral d		27. Manner of Deeth	28a. Dete		28b. Time o			ursing m		how injury occ		·y)			
	ding h. Afte fune	tior	→ Naturel 5 Pending	(Mon	th, Day Year)	Injury		njuryet Work? I □ Yes 2 □	l No.							
S	Attending I ar death. ector: After by the funer	Certification:	3 ☐ Sulcide 6 ☐ Could n	ot he	of Injuny - At he	omo form et				28f Location	(Street and Nu	mber or Pur	al Route Number.			
_	after Direct	in.	4 ☐ Homicide determi	buildi	ng, etc. (Specif	y)	reet, fectory, offi	CO .			wn, State)	noor or nore	ar rioble ivalliber,			
_	pital urs a pral		20- C-44i													
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier Certifying (Check only one)	Physician: To the end man	best of my kno asis of examine her-stated.	wiedge, deat tion end/or in	h occurred et the vestigation, in m	e time, date er ly opinion, dea	nd plece, ath occur	end due to the red et the time,	ceuse(s) end i , date end place	nenner es s e, end due t	teted. o the ceuse(s)			
	ithin o the	Me	29b. Signature and title of certifier	#11			29c. Lica	anse number		Т	29d. Data sign	ned (Month	Dev. Year)			
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			1/					1991	//		4/17	197				
2	\		30. Name and address of person w JAMES BOYD M	ho completed ceus	e of deeth (item	23e) (Type,	Print)				/					
2	/		STATES BOID N		/		LEONARD	TOWN, M	D.20	650						
	Sta	te	31. Date filed (Month, Day, Year)	1007 32.9	egistrar's Signa	iture P	11									
	Registr	ar	2014 1 8	199/	ha attituel	hon-ward	all									

MARGARET DAVIS

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legiple,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time f th Month WILLIAM HAM DENNIS, SR. JUNE 30, 1997 0417 4b. City, Town, or Location of Deeth 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yee 3/23/27 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Days 10XM 20 F Hours Yrs 70 MD 10c. City, Town or Location 10d. Inside City Limits Worcester Berlin 1 XYes 2 No 10f. Zip Code 10g. Citizen of Whet Country? 124 Cedar Ave. USA 21811 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Yes 2 No Specify: white 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Farmer Grain & Poultry 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28s.4 showing injury or other traumatic evens. 21215-0020 DENJU Maryland 2 Saltimore, 1

**Physician** 

/Medical

**Examiner** 

Director

þ

Be Completed

Funeral

Director

5. Social Security Number

10a, State

MD

11 Maritel Status

10e. Street and Number

217-28-4922

1 Never Married 2 X Married

3 Widowed 4 Divorced

Elementary/Secondery (0-12)

20a. Method of Disposition

4 Donation

Rillie P. Dennis

19a. Informent's Name/Relationship (Type, Print)

1 XBurial 2 Cremation 3 Removal from State

5 Other (Specify)

Barbara Dennis

10b. County

Usual Residence of Decedent

**Physician** /Medical Examiner

or Attending Physician: The lew requires that the death certificate be executed for use es the buriel-transit Division of Vital Records, P.O. Box 68760, this certificete To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral

actions that cardied the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, a cause on deth line. Immediate Ceuse (Finel disease or condition resulting in death) Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) Part II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Pert I. þ Completed Parishoral Be 25. Wes cese referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Z No ٩ Certification: 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 5 Pending investigation 1 Natural
2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homlcide 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. 29a. Certifier Medical (Check only one) 29b. Signeture end title of certifier 29c. License number

Approximete Intervel Between

Onset end Death

20c. Locetion - City or Town, Stete

Whaleyville, MD

Burbage Funeral Home

Dora A. Smack

7/2/97

19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

124 Cedar Ave. Berlin, MD

22. Neme end Address of Fecility

108 William St.

20b. Place of Disposition (Neme of cemetery, crematory or other place)

Dale Cemetery

23b. Did tobacco uee contribute to the cause of death? 3 Probably 4 Unknown 15 Yes 2 □ No

24a. Was en eutopsy

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth?

1 Yes 2€No

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Dete signed (Month, Day, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) HEARNE M.D. STEVEN 403 QUINCY

31. Dete filed (Month, Day, Year)

32. Registrer's Signature

State Registrar

if no effects was 

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

21009 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Lest) 2. Data of Death 3. Time of Deeth **Physician** Month 3() 1 9 9 7 June Carleton Joseph Diedrich Sr. 12:45a.m. /Medical 4b. City, Town, or Location of Deeth 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4165 Millburn Place Charles Indian Head If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplaca (Stete or Foraign Country) **Funeral** 1 M 2□ F Yrs. Director 577-05-4402 October 30,1917 Virginia Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter death with the Men/lend nent of Health end Mentle Ihygiene. Inti I flem 23 or 28e-f show int: If Iem 27 Is marked other than "natural", or items 23a or 28e-f show any or other traumatic event, In Medical Exprints, match the notified at any or other traumatic event, In Medical Exprints, match 10b. County 10a State 10c. City, Town or Location 10d. fnside City Limits 1 Yas 2 No Director Maryland Charles Nanjemoy 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 9050 Riverside Rd. U.S.A.

14. Rece - American Indian,
Bleck, White, etc. by Funeral 20662 12. Was Decedant Evar in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yas, Giva 1942— Year or Dates: 1045 Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 X Widowed 4 □ Divorced 1945 Completed 16a. Decedent's Usuai Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Director of Transportation U.S. GOT 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fathar's Name (First, Middle, Last) Be Theodore Diedrich Pansy Beach 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Carleton Joseph Diedrich, Jr. 5524 Champmans Landing Rd., Indian Head, Md. 20640 20b. Place of Disposition (Name of camatary, crematory or other place)

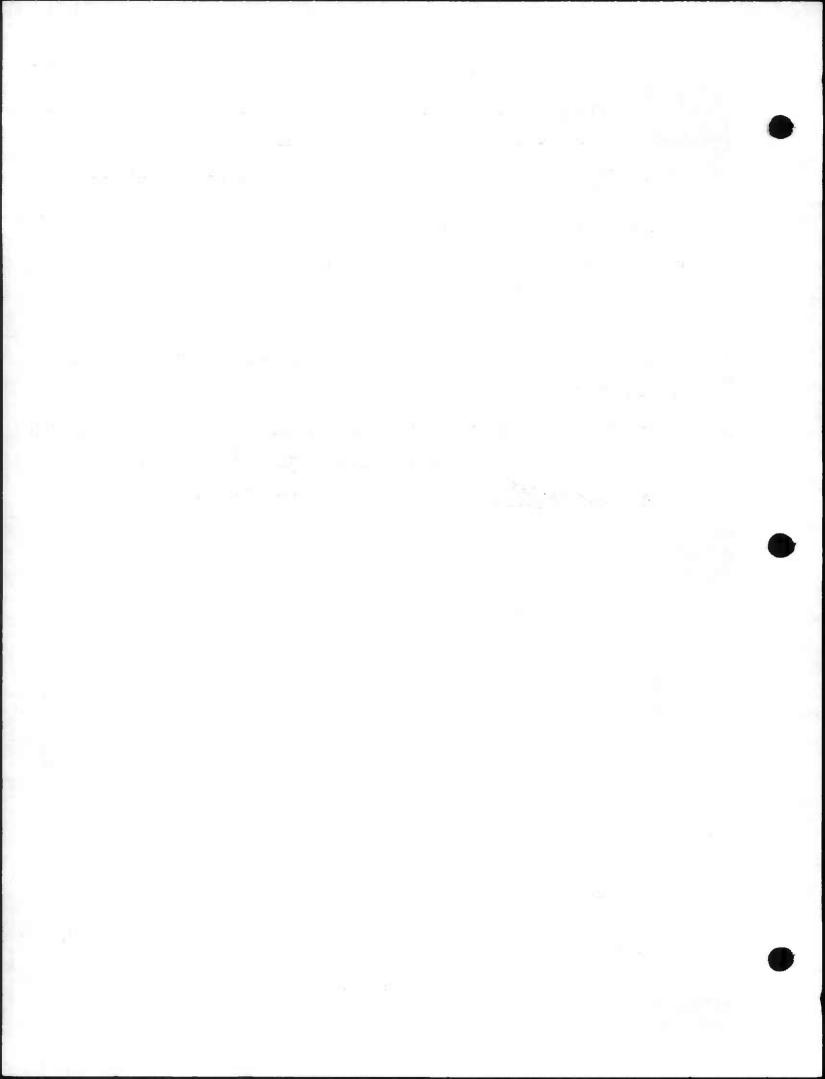
July 1, 1997 20e. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department Waldorf, MAryland Trinity Memorial Gardens 21. Signature of Funeral Service Lie 22. Neme end Address of Facility Williams Funeral Home, P.A. Do not enter the mode of dying, such as cardiac of respiratory arrest. Md. Interval Between Onset end Deeth **Physician** Immediate Cause (Final disaese or condition resulting in death) /Medical Prostate Cancer Examiner Due to (or as a consequenca of): Examiner attending physicien and for use es the burial-transit The lew requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of): certificate has been signed by the a irector, page 2 should be datached i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ð 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24e. Was en eutopsy performed? 1 Tyes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours eftar death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home .5 Thesidance 6 Other (Specify) 1 ☐ Yas 20 No P 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certification: 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of fnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature end titla of certifier 29c. License number 29d. Dete signed (Month, Day, Yaar) June 30, 1997 D28352 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Krishan Mathur, M.D. - P. O. Box 2729, La Plata, MD 20646

JUL 0 2 1997 July Davidson Royall

State Registrar 31. Dete filed (Month, Dey, Year)



	Physici	_	Decedent's Name (First, Middle, La     REBECCA	st) HATTIE	DARGA	N		2. Date of Deetl Month JUNE 2	Day 19	9 <sup>Year</sup>	3. Time of Deeth 5:45AM	
	/Medic Examin		4e. Fecility Neme (If not institution, giv 3940 BEXLE	e street end number)	#716		4b. City, Town, or L SUITLA		4c. County	of Deeth	CORGE'S	
	Funeral Director		5. Sociel Security Number 6. S 250-58-4568 Usuel Residence of Decedent	ex 7. Age	(In yrs. lest bir	thday) If Under 1 Yea Months Deys	Hours Min.	8. Date of Birth (Month, Dey,			elace (Stete or Foreign htry) MTER, SC	
1	or 28a-f ahow	Director	10a. State 10b. County  MARYLAND PRINCE  10e. Street end Number		10c. City, Tow	TLAND					Od. Inside City Limits  XXYes 2□ No	
de deine	23a or	3940 BEXLEY PLACE #716 20746  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Ye if Yes, specify Cuben, Mexican, Puerto Ricen,							10g. Citizen of Whet Country?			
5-0020	or ite	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - Americen Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuben, Mexican, Puerto Ricen, etc.) 15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuben, Mexican, Puerto Ricen, etc.) 16. Yes 2 No Specify: 17. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuben, Mexican, Puerto Ricen, etc.) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuben, Mexican, Puerto Ricen, etc.) 19. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuben, Mexican, Puerto Ricen, etc.) 19. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuben, Mexican, Puerto Ricen, etc.) 19. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuben, Mexican, Puerto Ricen, etc.) 19. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuben, Mexican, Puerto Ricen, etc.) 19. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuben, Mexican, Puerto Ricen, etc.) 19. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuben, Mexican, Puerto Ricen, etc.) 19. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuben, Mexican, Puerto Ricen, etc.) 19. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Yes, Spe									en Indien, etc.	
	iges 1 and 2 should be filed within 72 ho nt of Health and Mental Hygiene. If Item 27 is marked other than "natur or other treumatic event, Ite Medical	15. Decadent's Education (Specify only highest grade completed)  16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/In								siness/In	dustry	
CA 2		S P										
		To Be	17. Fether's Name (First, Middle, Lest)  18. Mother's Name (First, Middle, Maiden Surneme)									
Mary		19a. Informent's Neme/Relationship (Type, Print)  19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip  VIRGINIA BURWELL/ DAUGHTER 5976 ST. MORITZ DR. TEMPLE HILL										
2000			20a. Method of Disposition  1   Durial 2 □ Cremetion 3 □  Donation 5 □ Other (Specify	Removal from State	20b. Plece of cemeter	Disposition (Neme of y, cremetory or other place) OLN MEMOR	ece)	Date 2	20c. Location -	City or To		
	Department important any injury once.		21. Signeture of Funeral Servica Licen	S. Blay	ton	22. Name and Addr	ess of Fecility MA	RSHALL	'S OF		YLAND 20746	
P	hysician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line.  Appropriately onse									
	/Medical xaminer	disease or condition resulting in deeth)  e. Cantro ful monary and the properties of the consequence of the										
DO,	<u>ة</u> ا	i Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initleted events	b. End s liver	tage oue to (or es e	Pancreat consequence of):	ic canc	er wi	th			
SOX 66/60,	tending physic or use es the b	an/Medicai	thet initiated events resulting in deeth) Lest	d	ue to (or es e c	onsequence of):						

signed by the ett Id be deteched for Division of Vital Records, P.O. E to the Hospital or Attending Physicien: The lew requires that the dea Completed by Physic Be Certification: To After this of funeral dir

in 24 hours efter death.

The Funeral Director: After the funeral by the funeral by the funeral filled in by the funeral

24 hours e

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Tyes 2CXNo 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home Mesidence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28c. Injury et Work? 27. Manner of Deeth Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 XNaturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated.

29b. Signeture and title of certifie

29c. License number

29d. Date signed (Month, Dey, Year)

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

6.25.97

AL 7 4900 SILVER HILL RD. SUITLAND, MD

State Registrar

Medical

31. Dete filed (Month, Day, Yeer) JUN 27 1997

32. Registrer's Signeture

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

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					arylaria i	,	ificate of	Death	Wichtarry	Reg. No.				
Ť	Dhusis	·	1. Decedent's Neme (First, Middle, La	ast)					2. Data of De	eth	V	3. Time of Deat		
	Physic /Medi		Marjorie Hightow	er Dennam	d				Month June	Day 18, 1	Yeer 997	11:10 p		
	Exami		4e. Facility Neme (If not institution, gir					4b. City, Town, or				11.10 р		
			Doctor's Communit	y Hospital	_		]	Lanham		Princ	e Geor	rge's		
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	Director		263-07-7448	1□M 2∏F	78	Yrs.	INOTICIS DOYS	Tiodis Iviii	Jan. 1	10, 1919	Flor	ida		
	pui		Usual Residence of Decedent  10a. State 10b. County		10c. City, To		41							
	sho	5					ttion				10	d. fnside City Lin		
	Ne N	Director	Maryland Prince G	eorge's	Edmon	ston						1∭ Yes 2□		
	Nith De n						10f. Zip Code			10g. Citizen of	What Countr	ry?		
	8 23	Funeral	5122 Decatur Stre	T			20781			U.S.A.				
	item item	Š	11. Marital Status	12. Was Decedant Armed Forces?		13. We	es Decedant of H res, specify Cube	lispanic Origin? (S en, Mexican, Pue	Specify Yes or No to Rican, etc.)	b- 14. Rad Ble	ce - America ck, White, et			
20	172 hours after death with the Maryland "neturel", or items 23a or 28a-f show solical Examiner rivart be nutified at	by F	1 ☐ Navar Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ N If Yes, Give Yaar or Detes:	NO	10	]Yes 2∰ No	Specify:		Specif	v: Wh	ite		
8 P	ture		15. Decedent's E		16	o Dogođa	atia Haual Occum	otion		40h Kind of D				
21215-0020	C 49	Completed	(Specify only highest gr	ede completed)		(Give kii	nd of work done  NOT use retired	etion during most of wo d)	orking	16b. Kind of B				
2	filed within Hygiane. other than a	Eo	Elementary/Secondary (0-12)	College (1-4or 5	1+)		al Worke			Agricu		, _		
g	Hyg the int,	BeC	17. Fether's Name (First, Middle, Last	)					me (First, Middle					
Maryland		To B	William B. Highto	wer				Annie E	lizabeth	English	h			
ary	shound M	-	19e. Informent's Name/Reletionship (		19	b. Meilina	Address (Street	end Number or R				Code)		
	nd 2 lith a 27 is		Dorothy D. Curtis					Court, L						
Baltimore,	s 1 end 2 of Health a item 27 is other tre		20a. Method of Disposition						Date Date					
30	anto anto t: If i								6/22/07	December	1 14	· · · · · · · · · · · · · · · · · · ·		
	artm.		20b. Place of Disposition (Neme of cemetery, crametory or other place)  1 A Donetion 5 Other (Specify)  20c. Location - City or Town, Stete cemetery, crametory or other place)  Fort Lincoln Cemetery 06/23/97 Brentwood, Maryland  22. Name end Address of Fequility Francis Gasch's Sons Funeral Home, P.A.											
ñ	permit. Pages 1 and 2 should by Department of Health and Mante Important: If item 27 is marked any injury or other treumatic es once.		· Claudet	tes. 2	asch	Fr. 47	ancis Ga 39 Balti	isch's S	ons Fune enue, Hy	ral Home	e, P.A le, MI	20781		
			23a. Pert1. Enter the disease, or com shock, or heart feilure. List only	plications thet ceused one ceuse on each lir	the death. Do	not enter	the mode of dyin	g, such es cardia	c or respiretory e	rrest,		Approximete Intervel Between		
	Physician		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line.											
	/Medical Examiner		Immediate Ceuse (Finel disease or condition resulting in death)  • Acute Cardiopulmonary Arrest											
E.		_	Due to (or es e consequence of):											
	ed sit	je l	Acute and Chronic Congestive Heart Failure											
	end end I-trar	xau												
90	be a ician buria	E E	Sequentially list conditions, if eny, laading to Immediate cause. Enter Underlying Couse (Disease or injury that initiated evants	c. S/P Mit	ral Va	lve R	eplaceme	ent			9	Years		
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7.	that t ed by data								10	Yes 2□ No	3 Proba	ably 4 💢 Unkn		
Vital Records,	The law requires that the death cer ate has been signed by the attendir page 2 should ba detachad for use	d by							-27 mm	0.000 (C.110)e0	Oah Was			
Ö	v requir been s should	Completed							24a. Was perfo	an autopsy ormed?	evail	a autopsy finding leble prior to pletion of ceuse		
é	e law has t	dц										eath?		
	cata pag	S							10	Yes 2⊠No	10	Yes 2□ No		
	ician: The certificata rector, pag	Be	25. Wes cese referred to medical exeminar?						eth (Check only o	one)				
0	Attending Physician: If death. sector: After this certific by the funaral director.	၉	1 ☐ Yes 2 ☒ No	Hospital: 1 🖾 Inpatia		outpatient	3□ DOA Oth	4 U Nursing i	Homa 5 ☐ Resid	dence 6 □Oth	er (Specify)			
_	ing F	ii o	27. Manner of Deeth 1 Natural 5 □ Panding	28a. Dete of Injur (Month, Day	Year) 28b.	Time of Injury	28c. Injun World		28d. Describe	how injury occur	ed			
Sic	the the	cat	2 Accident investigation 3 Suicide 6 Could not b					Yes 2 □ No						
	after d Direct Jin by	Certification:	4 Homicide determined	28e. Plece of Inju building, etc	iry - At home, f :. (Specify)	erm, street	, factory, office		28f. Location (S	Streat end Numb wn, Stete)	er or Rurel I	Route Number,		
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	To the Hospital or Attending Physician: The I within 24 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edicai	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best o niner: On the basis of and mennar sta	examinetion e	e, deeth oo nd/or Inves	ccurred et the tim tigetion, in my o	ne, dete end plece pinlon, deeth occu	e, end due to the urred et tha time,	cause(s) end me date end plece,	nner es stat end due to ti	ted. he ceuse(s)		
	ithin 2 o the		29b. Signature end title of certifier	in all	11		29c. Licansa	number		29d. Date signe	d (Month, De	ey, Year)		
	F	A O MMINAYSUL DOS						009179 June 23, 1997			7			
1	10/	-	30. Neme end eddress of person who	completed ceuse of de	eth (Item 23e)	(Type, Pri				Julie Z.	,, 177	/		
1			Ata Moshyedi, M.D		,		•	e A, Gre	eenbelt.	Marvlar	nd 207	70		
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			Cei	rtificate of	Death	А	eg. No.	
Physic		1. Decedent's Name (First, Middle, Lest)  Evelup  Duff	. 6			2. Date of Deef Month June	Dey Year 21, 1997	
/Medi Exami		4e. Fecility Name (If not institution, give street end number)	9		4b. City, Town, or Lo		4c. County of Dec	
		Washington Adventist Hospit	tal		Takoma Pa	ırk	Montgome	ery
Funeral Director		1 DM 2 ME	(In yrs. lest birthday) 81 Yrs.	If Under 1 Yeer Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, June 22	yeer) 9. Bi	rthplece (Stete or Foreig country) ryland
dand ow		10a. State 10b. County	10c. City, Town or Lo	cation				10d, Inside City Limit
r 28a-f show	to	Maryland Prince George's	Hyattsvil	Le				1 N Yes 2 N
or 28	Director	10e. Street end Number		10f. Zip Code		1	0g. Citizen of Whet C	ountry?
23a	<u>a</u>	5805 42nd Avenue		20781			U.S.A.	
72 hours efter death with the Maryland natural; or items 23a or 28a-f show iteal Examinar must be notified at	by Funeral	11. Maritel Status  1 □ Never Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent E Armed Forces?  1 □ Yes 2 ☑ No. If Yes, Give Yeer or Dates:	n	Was Decedent of H f Yes, specify Cuba I □ Yes 2 ☒ No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Raca - Am Bleck, Whi Specify: W	
within 72 hours ene. than "natural", ne Modical Ex	Completed	15. Decadent's Education (Specify only highest grede completed)  Elementary/Secondery (0-12)  College (1-4or 5-	-)		petion during most of works d)	ng	16b. Kind of Business	:/industry
7	ပိ	8 17. Fether's Name (First, Middle, Last)	Bar Ma	aid / Wai	tress 18. Mother's Name		Surf Club	
0 = 0	o Be	John Ballard	•					
should by and Menta markad	2	19a. Informent's Neme/Relationship (Type, Print)	19b. Mailir	a Address (Street	Josephine		City or Town, Stete,	Zip Code)
alth ar alth ar 27 is ar trau		Peggy Williams - Daughter					, Maryland	
of Health of Health item 27 r other tr		20a. Method of Disposition	20b. Place of Dispo cametery, cren				20c. Location - City or	
Z == 3		1 ☐ Burial 2 【Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)			1	124/97	Alexandria	, Virginia
pemit. Page Department of Important: if any injury or once.		21. Signeture of Funerel Service Licansee	) 22 F1	Name end Addre	ss of Fecility	s Funer	al Home, F	
death certificate be executed  a strending physician end id for use as the burlal-trensit	√Medical Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated quests.	Due to (or es e consequent to (or es e conseq	uence of):  Uenca' of):  HEAR	T BL	dent		4 day 4 day
ires that the death cert signed by the attendin d be deteched for use	Physician/M	Pert II. Other significant conditions contributing to death but	-		en in Pert I.	23b. Did to	bacco use contribut	e to the cause of dear
s that med by se dete	by Pt	HTRIAL FI	BRILLI	TION		1 🗆 Ye	2 1 No 3 □ F	robably 4 Unkno
neen Seen Shoul	Completed					24e. Wes er perform		Were eutopsy finding eveileble prior to completion of cause of deeth?
	S					1 □ Ye	s 20No	1 ☐ Yes 2 ☐ No
s certific director,	Be	25. Wes case referred to medical exeminer?			26. Placa of Deeth	(Check only one	9)	
0,0	. To	1 ☐ Yes 2 ☐ No Hospitel: 1 ☐ Inpatlen: 27. Mennerer Deeth 28a. Dete of Injury			4 Li Nursing Hor		nca 6 Other (Spe	ocify)
h. After fune	tion	1 ☐ Netural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	Year) 28b. Time of Injury	28c. Injury Work	k? Yes 2 □ No	od. Describe no	w injury occurred	
within 24 hours after deeth.  To the Funeral Directors After this completely filled in by the funeral	Certification:	3   Suicide   6   Could not be determined   28e. Placa of Injurbuilding, etc.		28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)				
Fune Fune etely fil	edical	29e. Certifier (Check only one)  1 Certifying Phyeician: To the best of end manner stete	xaminetion end/or inv	occurred et the time estigation, in my op	ne, dete end plece, e pinion, deeth occurre	nd due to the ce	use(s) end menner e	s steted. e to the cause(s)
within 24 hours within 20 hours completely filled	Me	29b. Signeture end title of certifier  A	400	29c. License			Od. Date signed (Mont	
2/		30. Name end address of person who completed cause of dee	oth (Item 23e) (Type, F	OVER	PARKWA	4 G1	EENBER	7 -TMO 2077
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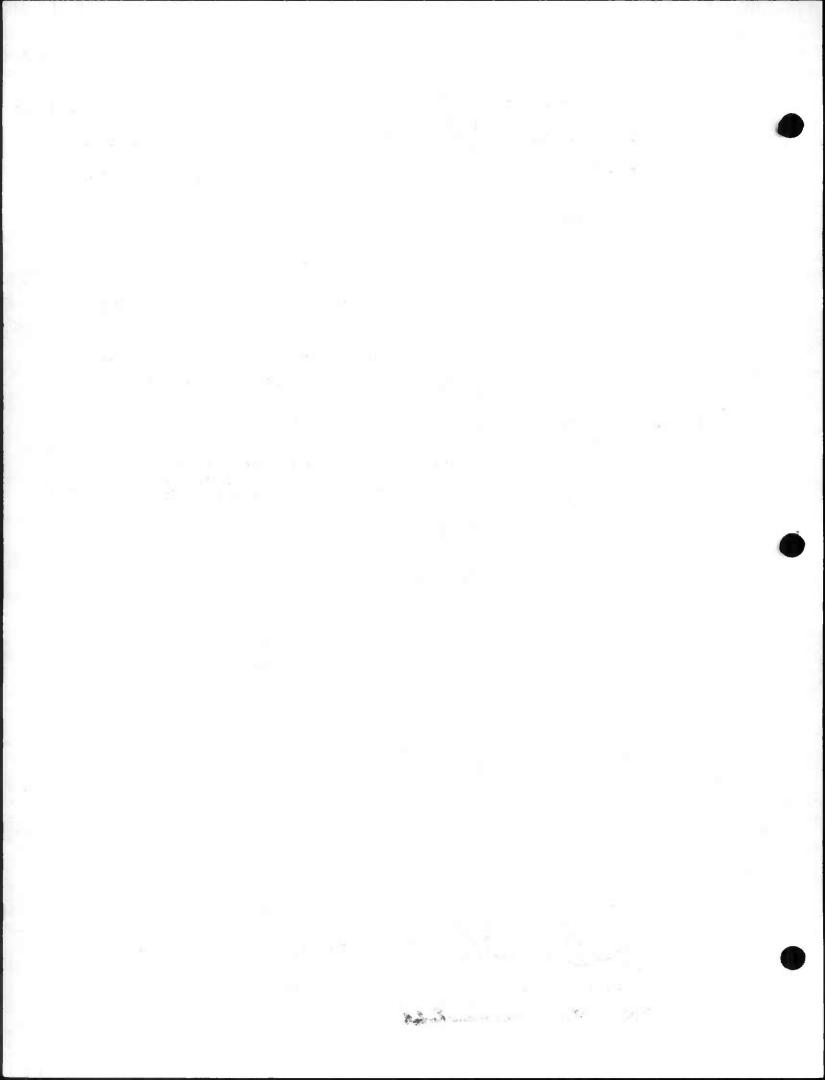
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State of Maryland / Department of Health and Mental Hygiene

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	Physic		Ma	attie L	ola De	nny					Month 6	23/	Day 9.7	Year	7	0:20	а
	/Medi Examii		4a. Facility Name (I	f not institution, gi	ve straat end n	um <i>ber</i> )		· · · · · · · · · · · · · · · · · · ·		4b. City, Town,	or Location of Do		4c. County	of Deeth		0.20	
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Ī	Funeral Director		5. Social Security N 228-22-2	1umber 6.	Sex 1□M 2DXF	7. Aga (/	n yrs. last bi	Yrs. If Ur Mont	ndar 1 Yaa hs Dey		lin. 8. Deta of (Month, 12-	Birth Dey, Ye	ar) 20	9. Birthp Cour R1C	ieca (St itry) hmo	eta or Foreig	n a
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					Cer	tificate of	f Death		Reg. No.		
		1. Decedant's Nama (First, Middla, Last)					·	2. Data of D	eath		3. Tima of Death
Physici		T4	OMAS		Do	LBER	RV	Month	= 24-	Yaar 1997	10.409
/Medie Examir		4a Facility Nama (If not institution, giva s	treet and number)			2,02,7	4b. City, Town, or	49			
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Eunaval		Social Sacurity Number     6. Sax		a (In vrs. last t	birthday)	If Undar 1 Yas				1	ace (State or Foreign
Funeral Director		578-76-4667 <sup>1</sup> 5	M 2□ F	41	Yrs.	Months Day		. (Month, D	ay, Year) -01-56		ace (Stàta or Foraigr ry) necticut
pue *		Usual Rasidance of Decedant  10a. Stata 10b. County		10c. City, To	wn or Loc	ation				10	Id Incido City Limito
a Maryle ta-f sho	Director	Maryland Prince Ge	eorge's	100. Ony, 10	01 600		trict Hei	ghts		10	od. Inside City Limits 1 XYas 2 No
£ 82	ē	10e. Street and Number				10f. Zip Coda	_		10g. Citizan of	What Count	ry?
h wil	<u>a</u>	2100 Addison Roa	ad South	#2			20747			USA	
dead and	Jer	11. Marital Status	2. Was Decedant E	Evar in U,S.	13. W	as Decedant of	Hispanic Origin? (S ban, Maxican, Puar	Specify Yas or N	lo- 14. Ra	ca - Amarica	ın İndian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Departmant of Health and Mentel Hygiene. Timportants if term 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 X Navar Married 2 ☐ Marriad 3 ☐ Widowed 4 ☐ Divorced	Armed Forcas?  1  Yas 2 17  If Yas, Giva Yaar or Datas:	No		Yas, specify Cu ☐ Yas 2 2 No		to Hican, atc.)	Specif	ck, Whita, a y: Blā	
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ld be enta cev	To B	James Lee Dolb	erry				Marv	Ann Hur	nter		
nari mari	F	19a. Informant's Name/Ralationship (Typ	ne Print)	10	h Mailin	Address (Stm	at and Number or R			State Zin /	Code
d 2 s		Mary Ann Dolberry					eet, S.E.		ington,	. ,	*
1 an Haal 9m 2 ther		20a. Mathod of Disposition	/ 1.10 OHEL			ition (Nama of	eet, b.b.	Data			
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To the Hospital or Attendi within 24 hours after death To the Funeral Director; A completely filled in by the f	edical	29a. Certifiar 1 Certifying Physi (Check only one)	cian: To the best of ar: On the basis of and manner sta	axamination a	ge, deeth and/or inva	occurred at tha astigation, in my	tima, date end place opinion, death occi	e, and dua to the urred at tha tima	a causa(s) and m	anner as ste	eted. tha cause(s)
Within to the comple	Me	29b. Signature and title of certifier	& Z			29c Lica	nsa number		29d. Date signs	d (Month D	Dav. Year)
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11/		region one	ma om			DO	0506	22	0/24	1/3/	•
0/		30. Name and eddress of person who con	npleted causa of da	aath (Item 23e	) (Type, P	rint) G	10506 YANCHIN	AND	SURAN	B	
		7501. SURRAT	75	HOH!	D.	CLEN	TON-N	25	Jul -1/10		

State Registrar 31. Data filad (Month, Day, Year) 32. Ragistrar's Signatura

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day **Physician** Month June 23, Ralph В. Echols 1997 6:55 PM /Medical 4e. Facility Nama (If not Institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hosptial Worcester Berlin 5. Social Security Number If Undar 1 Yeer If Undar 24 Hrs. 6. Sex 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year)
Dec 15, Birthplace (Stata or Foreign Country) **Funeral** XXM 20F Months Days Hours Yrs. 55 Director 578 56 4613 1941 WashingtonDC Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Meryland Department of Heelih end Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Exerciter must be nettind as once. 10a. Stata 10b. County 10d. Insida City Limits 10c. City. Town or Location Maryland Worcester Berlin 1 ☐ Yes 2 🔀 🖔 Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? #39 Cresthaven Drive 21811 United States Funeral 12. Was Dacedent Ever in U,S. Armed Forcas? 1 ☐ Yes ② Two If Yes, Give Yeer or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Rece - Amarican Indian, Bleck, White, etc. 1 ☐ Naver Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐XNX Specify: by White Specify: 3 Widowed 4 □ Divorced Completed 16a. Dacedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 System Analyst Federal Government 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be George Echols Dorothy Sweeney 19a. Informant's Name/Ralationship (Type, Print) 19b. Melling Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) Pamela B. Echols 108 Bluff Terrace, Silver Spring, MD 20902 20b. Piece of Disposition (Nama of cematery, cramatory or other piece) June 27, Detq 99720c. Location - City or Town, Stata 20a. Mathod of Disposition ABurial 2 ☐ Cremetion 3 ☐ Ramovel from State 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery Suitland, Maryland 21. Signeture of Funerel Sarvice Licenses 22. Nama and Addrass of Facility Lee Funeral Home, Inc 6633 Old Alexandira Ferry Rd, Clinton, Md 20735 23e. Pert 1. Enter the diseesa, or complications thet caused the deeth. Do not antar tha moda of dying, such es cardiac or rasplratory arrasf, shock, or haart fallura. List only ona causa on each lima. Approximata Intervel Batween Onset and Deeth **Physician** Immediata Ceusa (Final diseese or condition rasulting in daath) /Medical hours to I de Examiner Physician/Medical Examiner To the Hospital or Attending Physician: The lew requires thet the deeth certificate be executed within 24 hours effect deeth.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit physicien end s the buriel-trensit Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or injury that initiated avants rasulting in death) Lest Dua to (or as a consequence of): of Vital Records, P.O. Box 68760, Dua fo (or es e consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Wara eutopsy findings available prior fo Be Completed 24a. Was en autopsy performed? available prior fo completion of causa of daath? ASSLSSand Sueed alano 1 ☐ Yas 2 ☐ No 25. Was case rafarred to medical 26. Placa of Death (Check only ona) axaminar? Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Medical Certification: To 1 Yas 2 No 100 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Division Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On tha basis of axamination end/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to tha ceusa(s) and mannar stated. 29a. Cartifier 29d. Date signed (Month, Dey, Year) 29b. Signatura and fitie of certifier 29c. License number 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) 9733 Health Way Drive, Berlin, Md 21811 Toulemat, MD 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State JUL 0 2 1997 John Davilson Reveall Registrar

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DHMH 16 Rev 6/95

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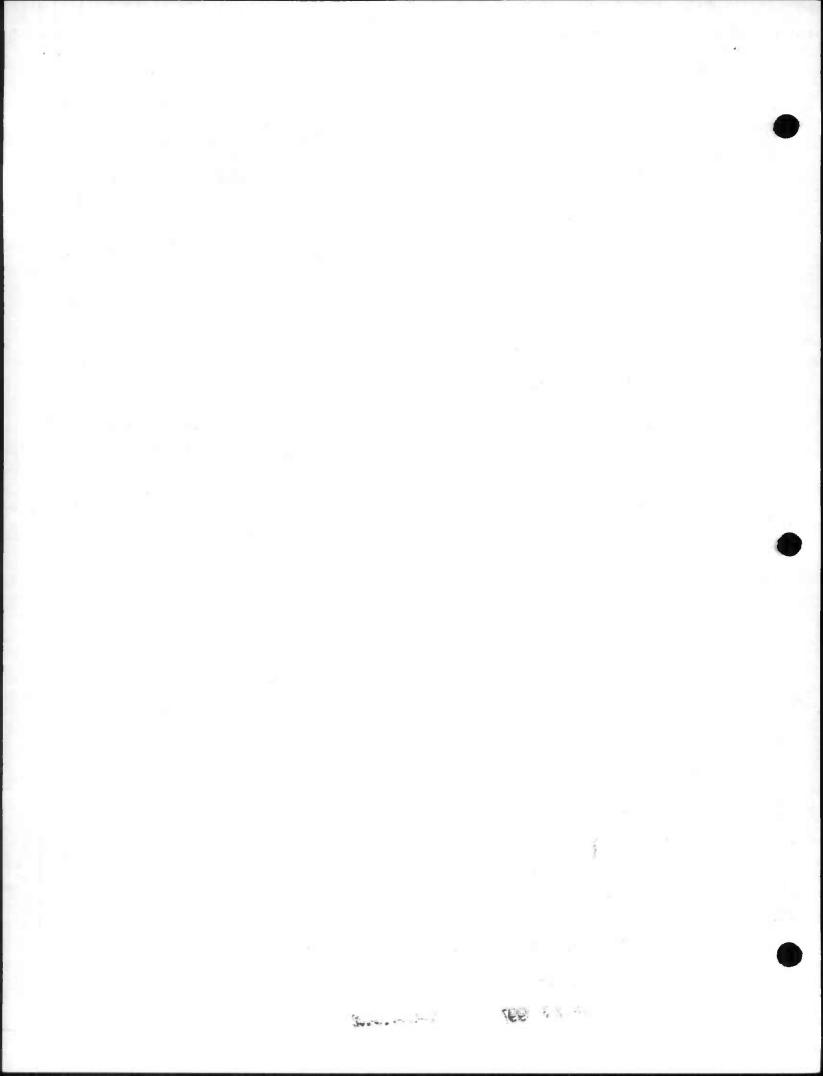
State of Maryland / Department of Health and Mental Hygiene 97 2 1 0 1 6

DAVID FINCHAM JR.

AS	P Items:	23a	part I,27,28a	-f per M	EO G-749	7/14/97	dh Ce	ertifica	te of	Death		Reg. No.		
	Physic	3-1	1. Decedent's Name (F	irst, Middle, La	st)						2. Date of D Month		Year	3. Time of Death
	Physici <b>*</b> /Medi		DAVID	F.	A	FINC	HAM,	JR.	•		JUNE	-	1997	12:27 A
	Exami		4a. Facility Name (If no.			n <i>ber</i> )				4b. City, Town, or	Location of Dea		-11-11-2	
				ELAIR						BALTIMO			LTIMOR	Œ
	Funeral Director		5. Social Security Numb 214–66–663	1 1	ex M 2□ F	7. Age (In yrs.	last birthda Yrs.	Months	er 1 Year Days		(Month, D	rth a <i>y, Year)</i> 25, 195!	9. Birthpla Count MARY	ace (State or Foreign ry) "LAND
	pue *		Usual Residence of De- 10a. State 10	cedent b. County		10c. Cit	y, Town or I	ocation					10	d. Inside City Limits
	Aarylen f show	0		BALTIMO	RE		ALTIMO						10	1 XYes 2 No
	the Mary r 28a-f sh notified	rect	10e. Street and Numbe						ip Code			10g. Citizen of	What Count	rv?
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0200	or its	þ	11. Marital Status 1 X Never Married 3 □ Widowed 4 □		Armed Fo 1 Tes If Yes, Giv Year or D	2 <b>X</b> No	,5. 13	If Yes, spe	ecify Cub	Hispanic Orlgin? (S pan, Mexican, Puerl Specify:	to Rican, etc.)		ce - America ck, White, e fy:	
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ylan	12 should be h and Mentel I is marked of traumetic eva	To Be	DAVID F. F								A. MORR			
, Mar	s 1 and 2 should be filed f Health and Mentel Hyg Item 27 is marked other other traumatic evant,		19a. Informent's Name.  IRENE A. M							NES, LEWE		19958	, State, Zip (	Code)
Baltimore, Maryland 21215-0020	6 = 5		20a. Method of Disposit 1	remation 3 [		State	Place of Dispendence	em atory or	other pla		Date 7/7/97	20c. Location		
Balti	permit. Pe Departmer Important: any injury once.		21. Signature of Funera	al Service Licar	see \\					ess of Facility BOCKTON ST		ME FOR TON, MD	FUNERA 2192	
	_		23a. Part1. Enter the d	isease, or com	olications that c	aused the deat	h. Do not e	nter the mo	ode of dvi	ing, such as cardia	c or respiratory	arrest		Approximate
	Physician /Medical Examiner	-	shock, or heart fe Immediate Cause (Fina disease or condition resulting in death)	·		TIC (MEP	ERIDINE or as a cons			TION				Interval Between Onset and Death
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of Vital Records,	sw requisite the second	Completed by									24a. Wa	s an autopsy ormed?	ava	re autopsy findings ilable prior to apletion of cause eath?
æ	0 - 5	Eo									12	Yes 2□No	1,28	r Yes 2□ No
ita	ysician: The scentificate director, pag	Be	25. Was case referred t	to medical						26. Place of De	ath (Check only	one)		
>	0 0	To	examiner? XXYes 2□ No		Hospital: 1 □ I	npatient 2 🗆	ER/Outpati	ent 3 D	Ot Ot	her: 4 Nursing H	Home 5 TyPies	idence 6 🗆 Ot	her (Specify	)
0	ding Ph th. After th funerel		27. Manner of Death 1 □ Natural 5	☐ Pending	28a. Date (Mont	of Injury h, Day Year)	28b. Time Injury	of	28c. Inju Wo			how injury occu		
Division	Attending or deeth. octor: After by the fune	Certification:	2 Accident	investigation	Tound:	6/30/97				Yes 2)(X)No	unknown			
N.	or At efter of Direct	Ē	4 ☐ Homicide	determined	28e. Place buildir	of Injury - At he	ome, farm, s v)	street, facto	ry, offica		28f. Location City or To	(Street and Num own, State) 511	ber or Rural 2 Belai	r Rd.,
	ospital hours e uneral C		20a Cartifica	O-Mit do - Di-		in house					Baltimor			
	Hos 24 ho Fune Stely 1	edlcai								ime, date end place opinion, death occu				
	To the Hospital or Attanding Ph within 24 hours efter deeth. To the Funeral Director: After th completely filled in by the funeral	M e	29b. Signature and title		end manr	or sidiou.				se number		29d. Date sign		
	- S - Ö		Aty	Mo	1 N	acl	5 M	P	o.c	.M.E		JUNE	30,1	
			30. Name end address	of person who	completed caus		111	Pen	n S	treet 1	Raltim	ore M	arwla	nd 21201
			31. Date filed (Month, D	S. 10	aden	Z, MI					our call	ore, M	туу	110 21201
	Sta	te	•	ay, rear) II 1 Λ 1		egistrar's Signa	ule -	<b>.</b> -	-	4.				

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 2 1 0 1 7

				State of Ivia	il ylallu / L	Department of I Certificate of			eg. No.	1 6	1017	
	Physici	an	1. Decedent's Name (First, Middle, Last)  Roger B Fuson					2. Dete of Deet Month June				
	/Medic Examir		4. F. W. N									
	Funeral Director	To Be Completed by Funeral Direc				yrs. last birthday) If Under 1 Year If Under 24 Hrs.  Months Deys Hours Min.				e (State or Foreign		
	ww m		Usuel Residenca of Decedent  10a. State 10b. County	10c. City, Town or Location			15.10	10d. Inside City Limits				
	e Mary		Maryland Calve	rt	Port Republic				1□Yes 2□No			
	23a or 28		10e. Street end Number 2 Azalea Road			10f. Zip Code 20676			10g. Citizen of Whet Country? United States			
Maryland 21215-0020	72 hours after death with the Marylend "naturel", or items 23s or 28s-f show		11. Maritel Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1≜ Yes 2 □ N If Yes, Giver 11. Year or DatesW	ver in U,S. o II	13. Was Decedent of If Yes, specify Cub	Hispenic Origin? (Speen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		a - American ck, White, etc		
	e 1 2		15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondary (0-12)  College (1-4or 5+) 5+		16a.	16a. Decedent's Usuel Occupation (Give kind of work done during most of work) life. DO NOT use retired)  Scientist		ing	16b. Kind of Business/Industry  Research/ NIH		try	
	permit. Peges t and 2 should be filed within Department of Haalth end Mental Hygiane. Important: If item 27 is marked other than any injury or other traumatic event, ITA MODE.		17. Fether's Neme (First, Middle, Last)  18. Mother's Na				18. Mother's Name	e (First, Middle, Maiden Sumeme)				
	shou end M a mer		19a. Informant's Name/Reletionship	(Type, Print)	19b	. Meiling Address (Street	t end Number or Run	al Route Number,	City or Town,	Stete, Zip Co	ode)	
e, N	f and faalth mm 27 i		Lucille A. Fusc	on-wife		Azalea Rd Disposition (Name of	. Port F	Republi	c, Mai	rylan	d 20676	
Baltimore,	Peges tment of It tant: If ite jury or of		1 ☐ Burial 2 ☐ Stremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special Control of the Con	fy)	Metro	y, cremetory or other ple	<sup>∞</sup> June 20 rematory	1997	Alexa	city or Town ndria	Virgini	
	Departiment Important Impo		21. Signeture of Funeral Servica Licansee  22. Name end Address of Fecility  Rausch Funeral Home  4405 Broomes Is. Rd. POrt Republic MD 2									
Division of Vital Records, P.O. Box 68760,	Physician Medical Examiner  by Street Physician and Physic	Completed by Physician/Medical Examiner	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.  Immediate Ceuse (Final disease or condition resulting in death)  Due to (or es e consequence of):  Due to (or es e consequence of):  Due to (or as e consequence of):  Due to (or as e consequence of):  Due to (or as e consequence of):									
	E 0.0		d.									
			Part II. Other eignificant conditions contributing to death but not resulting in the underly			the underlying cause gi	erlying cause given in Pert I. 23b.		Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown			
	aw requires to seen so should							24a. Wes er perform		eveile	eutopsy findings ble prior to etion of cause th?	
	E ata							1 □ Ye	s 20 No	1 □ Y	es 2 No	
	Physician: r this certific and director,	To Be	25. Wes case referred to medical examiner?  1 Yes 2 No Other: 4 Nursing Ho						nce 6 □Oth	or (Specify)		
	ding Ph. h. After thi funeral	Certification: T	27. Manner of Deeth  1 Naturel 5 □ Pending 2 □ Accident investigation	28e. Date of Injury (Month, Dey	28b. T	ime of 28c. Inju		28d. Describe ho			- 2	
	or Att		3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, fector building, efc. (Specify)				e 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)			oute Number,		
X,	To the Hospital or Att within 24 hours after of To the Funeral Direct completaly filled in by	edical	29a. Certifier (Check only one)  12 Certifying Phyelclen: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the bests of exeminetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner stated.									
)	with Tot	×	29b. Signeture end title of certifier	Kerken	_ /	29c. Licens D 2	3 46 8	29	Od. Date signed	(Month, Day	/, Yeer)	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mark Kushner									
	Sta Registra	te ar	31. Dete filed (Month, Day, Year)	3 1997) /a	s Signeture	sor Rochill						



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 0 1 8

						ertificate of	Death	P	leg. No.			
	u.		1. Decedent's Nama (First, Middle, Las	st)				2. Data of Dea	th	V-5	3. Tima of Death	
	Physician /Medical Examiner		Hidward William Fifowator					June 1	5, <sup>Day</sup> 997	Yaar	1635	
			4e. Fecility Nema (If not institution, give	a straet and number)			4b. City, Town, or Lo	ocation of Deeth	eeth 4c. County of Death			
			48333 Driftwood Court, Apt. 200 B  5. Social Sacurity Number 6. Sax 7. Aga (in yrs. last birthdey) If Under 1 Yaar   If Under 24 Hrs. 8. Data of Birth 9. Birtholaca (State or Entering									
	Funeral	Director	5. Social Sacurity Number 6. S	ax 7. Aga (In	yrs. last birthde	y) If Under 1 Yaar Months Days	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, Year) 9. Birthplaca (Sta			ca (State or Foraig	
	gas 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mantal hygiana. If item 27 is marked other than "natural", or items 23a or 28a-1 show not other traumatic event, the Medical Examiner must be notified at		214-01-7658	■M 2□F 74	Yrs.	Monaro Bayo					inia	
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Speed										10	d. Insida City Limits 1 ☐ Yas 2 ☐ No	
3			Maryland St. Mary's Lexington Park  10e. Street and Number									
#		급	10e. Street and Number 10f. Zip Coda						0g. Citizan of V	Whet Countr	y?	
=		eral	48333 Driftwood C	Court, Apt.  12. Wes Decedant Evar		20653	tion and Odd Ind (On		United			
_ 6	iter i	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forcas?	110,5.	<ol><li>Was Decedant of If Yas, specify Cub</li></ol>	en, Maxicen, Puarto	Rican, etc.)		e - Amarica k, Whita, e		
20	within 72 hours aftar ana. than "naturs!', or ite ire Medical Examine	by F	3 ■ Widowed 4 □ Divorced Year or Datas: WWII				fas 2 No Specify:			Specify: White		
21215-0020		- G	15. Decedant's Ed	lucation	16a, Dao	cedant's Usual Occup	pation		16b. Kind of Bu			
215	in 72	Completed	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)				ing	100.11.100.01		uny		
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	d 2 should be filed within h and Mantal Hyglana. 7 Is marked other than "traumatic event, the Mer	Be C	17. Fathar's Nama (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Sumem	a)		
Maryland	Aanta Aanta di Control	ToE	Victor Fitzwater				Ina Mae	Rhodes				
an	and h		19e. Informant's Name/Ralationship (7	'ype, Print)	19b. Ma	Illing Addrass (Street	end Number or Run	al Routa Numbe	r, City or Town,	Steta, Zip C	Coda)	
<b>S</b> 6	alth a 27 ls		Richard A. Fitzwa	ater, Son	4816	5 Mayflowe	er Drive,	Lexingt	on Park	, MD	20653	
ore	itam itam		20a. Mathod of Disposition		Ob. Plece of Dis	position (Name of rematory or other pla	ce)	Dete	20c. Location -	City or Tow	n, Steta	
m	permit. Pagas 1 and 2 Department of Health e Important: If Itam 27 Is any Injury or other tra		1 ■ Burial 2 ☐ Cremation 3 ☐			eterans' Cer		/20/97	heltenhan	. Marv	land	
Baltimore,	Dapartman Important: any Injury		21. Signature/of Fufferal Survice Com	gens F		22. Name end Addra	ss of Facility			,		
<b>m</b> §	90 5 6 8		West and West Plan	1./		Brinsfield				- 1 20	650	
			Michael K. Blan 23a. Perti. Enter the disease, or comp	olicetions that caused tha		P.O. Box 2 enter the mode of dying				1 1	Approximeta	
P	Physician /Medical		23a. Perf1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast,  Approximete Interval Batween Onset and Deeth  Immediate Cause (Finel disease or condition resulting in death)  Pus to (or as a consequence of):									
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on the	icata be axecuted physician and s the bunal-transit	Examiner	Sequentially list conditions.	b. Dua	to (or as e cons	equance of):						
0,			Sequantially list conditions, if any, laading to immadiata causa. Entar Undartying Cause (Disaese or injury			i						
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0 2	2 9	sicia	Part II. Other significant conditions co		t rasulting in tha	underlying causa giv	van In Part I.	23b. Dfd to	obacco use co	itribute to 1	he cause of death	
U. ‡	t by the	Physicia		ontributing to death but no	-		van In Part I.		obacco use con les 2□ No	ntribute to 1	V	
Is, P.O	igned by the	by Physician/N		ontributing to death but no	-		van In Part I.				V	
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	ata has bean signed by the page 2 should be datache	þ			-		van In Part I.	1 □ Y	es 2□ No in autopsy med?	3 ☐ Probe	a eutopsy findings able prior to pletion of cause eath?	
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					•	Certif	cate of De	eath		Reg. No.		Com. II	019
	Physic	ian	Decedent's Neme (First, Middle, La     John Jackson Fre	•					2. Dete of D Month May		199 <sup>Yeer</sup>	3. Tim	ne of Death
Ĭ	/Medi Examir		4a. Fecllity Nama (If not institution, giv 317 Norris Road					City, Town, or L	ocation of Dec	th 4c. Co	unty of Deett Mary	h	rm
	Funeral Director		5. Social Security Number 6. S 217-42-2285		a (In yrs. last bii 51			Undar 24 Hrs. lours Min.	8. Deta of B (Month, D December	irth Dev. 21, 194	9. Birth	hplaca (Sta untry) rgini	ate or Foreign
	and		Usual Residence of Decedent  10e. Stete 10b. County		10c. City, Tow	m or Location	n					10d Insid	le City Limits
	Maryl Flasho	tor	Maryland St. Mar	y's	Great								Yas 2 No
	n with the 3a or 28a	ai Directo	10e. Street end Number 317 Norris Road			1	0f. Zip Code 20634			10g. Citizen	of What Con	-	
21215-0020	in 72 hours after death with the Maryland "netural", or items 23s or 28s-f show ledical Exemplear must be notitied at	by Funeral	11. Maritel Status  1 Navar Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forcas? 1 □ Yes 2 ■ N If Yes, Give Yaar or Detes:			Decedent of Hispa s, specify Cuben, N res 2 ™ No Si	nlc Origin? (Sp lexican, Puerto pecify:	pacify Yes or No Rican, atc.)		Race - Amer Black, Whita ecify: Whi	a, atc.	n,
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Maryland	d la b	To Be	Leonard Freeman				10.	Venus		o, molular Sur	nome		
ary	E B E E	F	19a. Informent's Neme/Relationship (	Type, Print)	198	o. Meiling A	idress (Street and			ber, City or To	wn, Stete, Z	(ip Code)	
	475		Jackleen Freeman	Wife			ris Road						
Baltimore,			20a. Method of Disposition  1  Burial 2  Cremetlon 3  4  Donation 5  Other (Specific			ry, cremeto	n (Nema of ry or other plece) n Cremato	DEV.	Dete 5/3/97		ion - City or 1		
Balti	permit. Pages Department of Important: If Is any Injury or once.		21. Signature of Furieral Service Uces	nsfield, J	r. M0005	22. Ne	ma and Address of Asfield F	Fecility					
68760,	Centificate be executed had placed and had physician and under transit as the burial-transit	Physician/Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth)  Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest	ь. <u>Са</u>	Due to (or es e	consequand	se of):	Lar	ym	4		br	no
. Box	of the	ician	Pert II. Other significent conditions or		it not resulting i	n the under	vina cause aiven Ir	Port I	23h Di	d tobacco use	contribute	to the car	see of death?
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Records,	aw req is beer 2 shou	Completed t							24a. We	s an autopsy formed?	a	Were eutop vailable pr completion of deeth?	osy findings for to of cause
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Viital	Physician: rthis certifica	Be C	25. Wes case referred to medical examiner?	Hospital:			Other		th (Check only				
o	iding Physich. Th.: After this sinneral d	tion: To	1 Yes 2 No  27. Manner of Deeth 1 Netural 5 Pending 2 Accident Investigation	28e. Date of Injur (Month, Dey	y 28b.	utpetient 3 Time of Injury	28c. injury et Work?	4 □ Nursing He	oma 5 A Res 28d. Describe			ify)	
Division	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ry - At home, fe . (Specify)	erm, street, l	actory, office		28f. Location City or To	(Street end Nown, Stete)	umber or Ru	ral Routa I	Vumber,
	e Hospit 24 hour e Funera	edical	29a. Certifier (Check only one) Certifying Physics (Check only one)	ysician: To the best on the best of and manner stell	examination en	e, deeth occ d/or Investig	urred et the time, d pation, in my opinio	late end place, on, deeth occur	end due to the red et the time	e ceuse(s) and , date end pla	f manner es ce, and due	steted. to the ceu	se(s)
	Vithii To th	M	29b. Signatura and title of certifiar	tarle	JE/K	10	29c. License nu	641°	9	29d. Date si	gned (Month	Dey, Yea	ar)
			30. Name and address of person who of James P. Jarboe,	4.1-	eth (ttem 23e)		nardtown	, Mary	land 20	650	, ,		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registre	r's Signature								

• In the case sens on SETE presser 

Funer Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiane. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, fra Madeal Evantiner must be notified at

To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, paga 2 should be detached for use as the bunel-transit

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State of Maryland / Department of H	lealth and Mental Hygiene 37

State of Maryland / Department of Health and Mental Hygiene

21020

				C	ertificate of	Death		Reg. No.		-1040
Discount of		1. Decedent's Name (First, Middle, Las	st)				2. Dete of De	eth	Viene	3. Time of Counth
Physici /Medic		Gordon I	Theodore	F	edders		June 3	L, 1997	Year	5:30 PM
Examin		4e. Fecility Neme (If not institution, give	re street end number)			4b. City, Town, or L	ocation of Death	4c. Count	y of Deeth	
		Charlotte Hall Ve	eterans Home			Charlotte			Mary	s
Funeral Director		5. Social Security Number 6. S 074–12–9583 1  Usual Residence of Decedent	Sex 7. Age (In yrs.	lest birthda Yrs.	Months Days		8. Date of Bir (Month, De Jun 27	v. Year)	Coun	lace (Stete or Foreign try) York
-f show	tor	10a. State 10b. County  Maryland St. Mar		y, Town or					1	0d. inside City Limits 1 ☐ Yes 2 No
3a or 28a	ai Director	10e. Street and Number 16690 St. Jeromes			10f. Zip Code 20628	3		10g. Citizen of		try?
Department of health and Mental Hygiane.  The statement of health and Mental Hygiane.  The statement of them of its marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funera	11. Maritel Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 🏿 Yes 2 🗆 No	,S. 1	3. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Speen, Mexican, Puert	pecify Yes or No Rican, etc.)	- 14. Ra	ca - Americ ck, White,	
itural', o	by	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Ed	If Yes, Give Year or Dates:	16e De	1 ☐ Yes 2 🔀 No cadent's Usuel Occu			Specifi 16b. Kind of B	WILL	
ane. than "ne	Completed	(Specify only highest gra	College (1-4or 5+) 3 Vears	(Gi	ive kind of work done b. DO NOT use retire Lectronic	during most of wor ed)	king			
d other	Be	17. Fether's Neme (First, Middle, Last) Theodore	)		rectionic	18. Mother's Nam		Maiden Surner	m <i>e)</i>	nment
and Mer is marke aumatic	To	19e. Informent's Name/Relationship (7		19b. Ma	ailing Address (Stree		ral Route Numbe		Amos , State, Zip	
freath frem 27 other tr		Mark W. Fedders/S  20a. Method of Disposition	20b. F	Placa of Dis	John Shar sposition (Neme of cremetory or other pla		pring Hi	20c. Location	3717 - City or To	
rtant: If		1XX Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify	y) MD		rans Cemet	ery	5/5/97	Chelter	nham,	MD
Important In Suny In S		21. Signature of Funeral Service Licen  23a. Part 1. Enter the disease, or compshook or heart failure. List only	Landenier		22. Name end Addro Mattingles P.O. Box 2 enter the mode of dy	7-Gardine 270, Leon	ardtown.	Marvla		20650 Approximate Intervel Between
ysician ledical		Immediate Cause (Final			re Ale					Onset end Deeth
aminer	er	disease or condition resulting in death)			sequence of):					DYKS
within Extracts of the there in the first this centificate has been signed by the attending physician and completely filled in by the funeral diractor, paga 2 should be detached for use as the buriel-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last	c		sequence of):					
ttending or use a	Physician/M		d							
the a	ysic	Part II. Other significant conditions co	ontributing to death but not res	ulting in the	underlying cause gi	ven in Pert I.	23b. Dld	tobecco use co	ontribute to	the cause of death?
gned by be detac	by Ph	HEMOCHROM					10	Yes 2□No	3 □ Prot	pably 4 Unknown
a 2 should	Completed	Myelo Dy	SPLASIA				24a. Was perfo	an eutopsy rmed?	CO	ere eutopsy findings eiteble prior to mpletion of cause deeth?
pag.	S						10	Yes 2000	10	Yes 2 No
actor	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Dea				
this cal dir	7	1 165 22010			tient 3LI DOA		ome 5 Resid			1)
or: After the funer	Certification:	27. Manner of Deeth  1 Natural 5 Pending 2 Accident investigation		28b. Time Injury	y Wo	iryet ork? ]Yes 2□No	28d. Describe	how injury occu	rred	
al Direct ed in by	Certifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ HomicIde determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm,	street, factory, offica	5	28f. Location (3 City or Tox		ber or Rure	I Route Number,
n 24 nour	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	ysician: To the best of my kno niner: On the besis of exemina end manner stated.	wledge, de tion and/or	ath occurred et the ti investigation, in my	me, date end place opinion, death occur	, end due to the rred et the time,	cause(s) end m date end place,	enner es si end due to	eted. the cause(s)
Tot	×	29b. Signature and title of certifier	A I	١.	29c. Licen	se number		29d. Date signe	ed (Month,	Dey, Year)
		30. Name end eddress of person who d	Completed cause of death /Item	DI N	J D-	4443	6	JUNE	02	1997
		31. Date filed (Month, Day, Year)	MAR J PATEL	aup (Typ	603 Pas	TOFFICE R	D W.	ALDORF	MD	20602
Stat Registra		JUN 04 1	32. Registrer's Signe	Less-Ra	rdall					

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				Olale of		Cei	tificate o	Death	F	leg. No.		
1	Physic		1. Decedent's Name (First, Middla, EULALTA F						2. Dete of Dea Month	Day		3. Time of Deeth
N	/Medi Exami		4e. Facility Name (If not institution,					4b. City, Town, o	or Location of Death			10:15p.n
			Mariner N	ursing H	Iome			Clint	on	P.G.	Year 97 Country of Death G.G.  9. Birthplace Country) Texas  10d.  10d.  11d.  11d.  12en of Whet Country? S.A.  14. Race - American In Black, White, etc.  Specify: Black and of Business/Industri  1 Vate Surnama)  1 Town, Stata, Zip Coo. G, Md. 207 Cation - City or Town, entwood, Edwards Land, Md.  Apprinte On: 5  12ec contribute to the River and Signature Sy 24b. Were e evailable confident Sy 24b.	
	Funeral Director		5. Social Security Number  457-36-2274  Usual Residence of Decedent	5. Sex 7.	Age (In yrs. 87	last birthdey) Yrs.	If Under 1 Yes Months Day			Yaar)		place (Stata or Foraign htry)
	yland		10a. Stata 10b. County		10c. Cit	y, Town or Lo	cation				1	Od. Inside City Limits
	the Marylar 28a-f show	ctor	MD P.G.		С	linto	n					1 🎇 Yes 2 🗆 No
	vith th	Dire	10e. Street end Number				10f. Zip Code		1			itry?
	eath with	Funeral Director	9211 Stuart La	12. Was Decede	int Ever in 11	S 12 1	2073		(Capaily Vacas No			on Indian
21215-0020	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show edites! Examinat must be notified at	by	1 Never Merried 2 Marrie 3 DW idowed 4 Divorced	Armed Force	es? ⊒No		Yes, specify Cu		(Specify Yes or No- erto Rican, etc.)		White,	etc.
5-0	72 ho	Completed	15. Decedent's (Specify only highest	Education		16a. Deced	lent's Usual Occi	upation	vorkina			
121	within iene. than "	mpl	Elemantary/Secondary (0-12)	Collaga (1-4	or 5+)		oo Not usa ratir ekeeper	a during most of wed)	ional g	n mi	<b>L</b> a	
9	Hygied sther	e Co	17. Father's Nama (First, Middla, La	st)		nouse	reeber		ame (First, Middla,	~		
Maryland	2 should be fi and Mental h la marked of raumatic ever	To Be	unknown						a Bailey			
Man	2 sho and I a ma	ľ	19a. Informant's Name/Ralationship	(Type, Print)				at and Number or	Rural Routa Number	r, City or Town, S		
	1 and Heelth em 27 ther to		Patsy Woods 20a. Method of Disposition		20h P		)4 Burl	eigh S	77			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "naturnany injury or other traumatic event, I'm Medical ance.		Burial 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spe		to C	ematary, cram	atory or other pl					
altii	permit. F Departme Importan any Injur	i	21. Signature of Funeral Service Lie	* *								
m	Depa Impo any Ir		Vanice.	-Awa	rol	- 1						
		16 3	231 Part1. Enter the disease, or co shock, or heart failure. List or	mplications thet causely ona cause on each	sed the death							Approximate Interval Between
	Physician /Medical		Immediate Cause (Final	1			61.	λ				Onset and Death
	Examiner		diseese or condition resulting in death)	a Hype				RT U	ISTASE			5 x 4RS
		ner			Due to (o	r as e conseq	uence of):					
	eath certificate be executed ettending physician and for use as the bunal-transit	Examiner	Sequentially list conditions,	b	Due to (or	r as a conseq	uence of):					
68760,	be ex ician a burial	a E	Sequentially list conditions, if any, leading to immediata ceuse. Entar Underlying Cause (Disease or injury that initiated events	C								
687	ficate phys is the	edical	that initiated events resulting in death) Last		Due to (or	es e consequ	ence of):					
	h certi	M/UE		d								
B	the ett	Physician/N	Part II. Other significant conditions	contributing to death	but not resu	Iting in the un	derlying ceuse g	iven in Part I.	23b. Did to	bacco use conti	ibute to	the cause of death?
P.0	that the de ed by the deteched								1 🗆 Y	es 2 No 3	Prob	ebly 4 Unknown
Records,	S 60	d by							24a. Was a	n autonsv	24b. We	re eutopsy findings
000	w require s been si	Completed							perform	ned?	COL	rilable prior to
<u>~</u>	The law ate hes pege 2	mo							1 □ Ye	s 2 No		Yes 2□ No
Viita		Bec	25. Was cese referred to medical examiner?					26. Place of D	eeth (Chack only on			
<del>_</del>	this aldi	2	1 Yes 2 No	Hospital: 1 Inpe		ER/Outpatient	3LI DOA		Home 5 ☐ Reside			)
	g age	tion	27. Manner of Death  1 □Natural 5 □ Pending 2 □ Accident Investigat		Day Year)	28b. Time of Injury	28c. Inju Wo M 1 [	ıryet ork? ]Yas 2∐No	28d. Describe ho	ow injury occurred	1	
Division	Attending ir death. bctor: After by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of	Injury - At ho	me, farm, stre	et, factory, office				or Rurai	Routa Number,
ā	tal or rs afte al Dire	Cert	4 Homicida determine	building,	atc. (Specify	)			City or Town	n, Stata)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Cartifier (Check only one)	miner: On the basis	of examinati	vledga, daath ion and/or Inv	occurred at tha t	ima, data and plac opinion, daeth occ	ce, and dua to tha ce	eusa(s) and manr ata and place, an	ar as sta	ated. tha causa(s)
	vithin 2 To the	Mec	29b. Signeture and ittle of certifier	and manner	statad.		29c. Licen	se number	2	9d. Data signed (	Month. L	Dav. Year)
	6		* Knm				20	391				
,	(1)		30. Name/and/address of person wh	o completed cause o	f death (Item			, , ,		4467	T)	1111
			DR JEFFREY	KELMA	W	652	5 1561	LREST	ROAD, L	1 YATTSUI	116,	MD
	Sta	10	31. Date filed (Month, Day, Year)	32 Regis	strar's Signat	ure			,	/	/	

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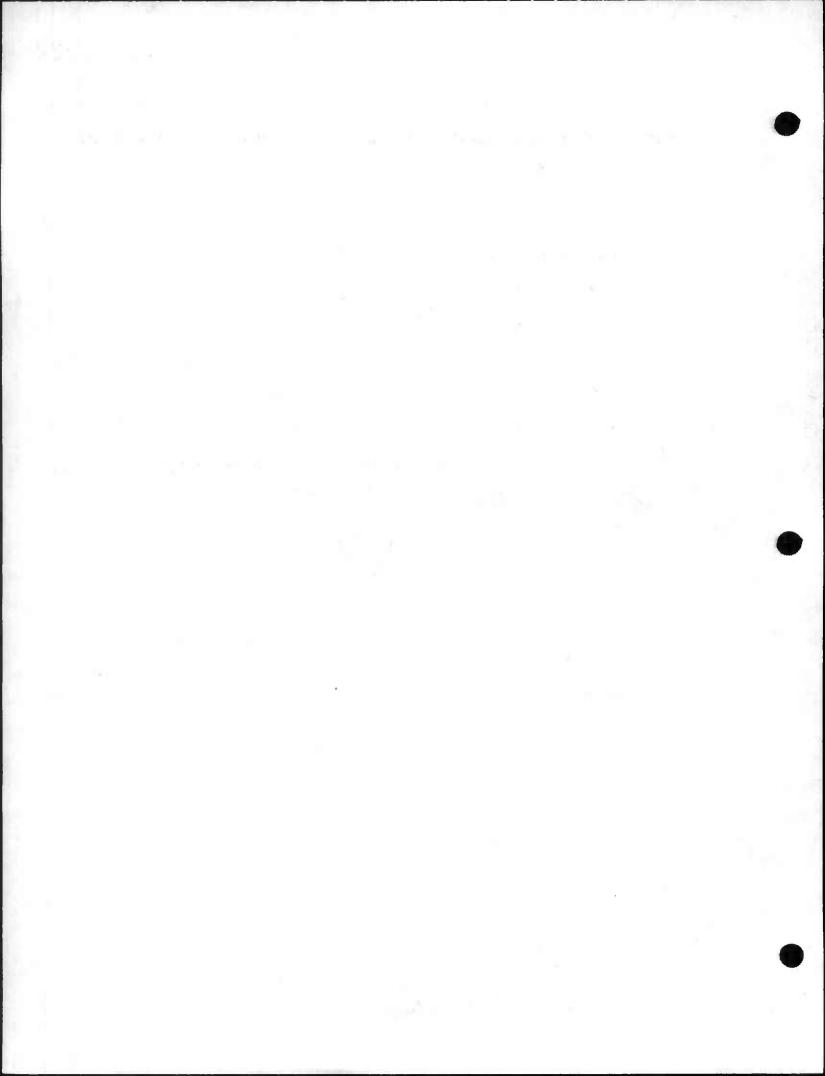
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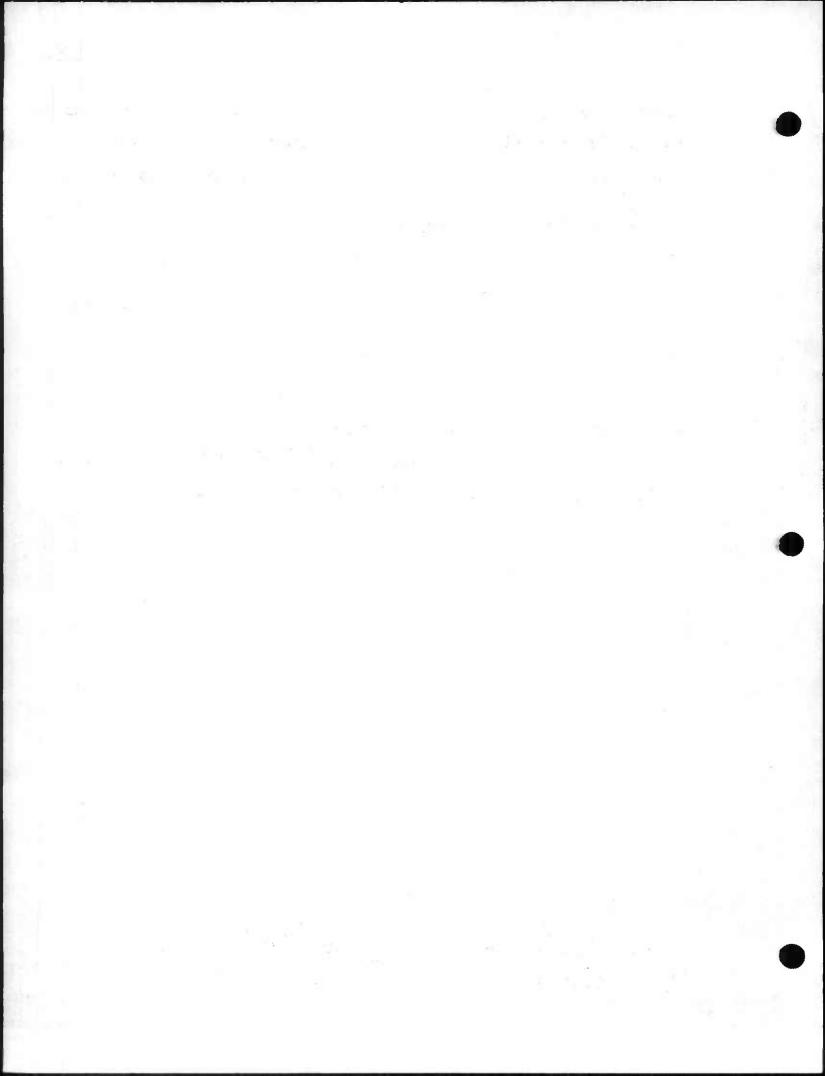
							C	ertifica	te of	Death	,	Reg. No.			, 100
	Dharia		Decedent's Name (i	First, Middle, Le	st)						2. Date of De	eth	Veer	3. Time of	Deeth
	Physic /Medi		Edward J	oseph	Ford,	Jr.					JÜNE	24,	1997	8:2	5am
	Exami		4e. Fecility Name (If no							4b. City, Town, or					
			GREATER			EDICA	L CE			TOWS		BA	LTIMO	DRE	
	Funeral Director		5. Social Security Num 213-32-8	395	M 2□F	7. <b>Age</b> (In yrs. 61	lest birthd Yrs	Months	er 1 Year Deys			th by, Year) 36	9. Birthp Coun Ma 1	lace (Stete or try) Cyland	Foreign
	and and		Usuel Rasidence of De 10a. State 10	ob. County		10c. Cit	y, Town o	r Location					Country of Deeth  BALTIMORE  9. Birthplace (St. Country) Mary 1:  10d. Inside the second of the seco	Od Inside Cit	v Limits
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	or 2	Dire	10e. Street end Number						ip Code					try?	
	ath v	rai	2102 Co	raltho					220			U.S.			
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5-0	72 h	etec	(Specify	. Decedant's Econly highest gra	ducetion	0010	16e. De	cedent's Us	ual Occu	pation during most of wo	orkina	16b. Kind of E	Businass/Inc	lustry	
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and	Duid be fi Mantal H arkad ot atic ever	Be	17. Father's Name (Fir.							18. Mother's Na	me (First, Middle,	, Maiden Sumei	me)		
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Baltimore,	Peges nent of I int: If its		1 Burial 2 C 4 Donetion 5			tate	_				5 10 5 10				
	pemit. Peg Department Important: I any Injury o		21. Signature of Funar			Tre	ento			ry ess of Fecility	6/26/9	/ Uppe	rco,	MD 2.	1155
ä	permit. Departr importa any Inf		D 01	- /	1) 5	_					lome, 93	34 S.	unty of Deeth  ALTIMORE  9. Birthplace (Stete or Country) Maryland  10d. Inside City 1 Yes of Whet Country?  A.  Race - American Indian, Black, Whita, atc.  ecity: White of Businass/Industry  imore Sun I freme)  Sown, State, Zip Code) re, MD 2122 on - City or Town, State erco, MD 2: Main St ead, MD 21( Approximate Intervel Betw Onset end D  24b. Were eutopsy fire overlable prior to conform to conform the country of death?  Other (Specify)  countribute to the cause of the second of death?  Other (Specify)  Sourced  Other (Specify)  Sourced  Imannar as stated.  Cee, end (Month, Dey, Yeer)  Other (Specify)  Sourced		
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Ç.	Physician		shock, or heert fa	illure. List only	one cause on ee	och line.			,		,			Intervel Betw Onset end D	reen
þ.	/Medical		Immediate Ceuse (Findisease or condition	el	SE	P515							i	31	
В	Examiner		resulting in death)		ө. 🥥 🗀	1000	r es e con	sequence of	):				1	- 4	_
-	₽ ≈	iner			. CIF	2RHO			,					5 1	
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Ö,	e axe		Sequentielly list condit if eny, leeding to imme ceuse. Enter Underlyin Ceuse (Diseese or Inju-	ng	HEY	ATIT	IS	B					i	10	1
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	that the ded by date										1 🗆	Yes 2 No	3 Prob	ably 4 U	nknown
Division of Vital Records,	uires sign	d by									24a Wes	en eutopsy	24b. We	re eutopsy fir	ndinas
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Ø	n: Tr ficate or, pe		25. Wes cese raferred	to madical							10,	1	1 L	Yes 2∐ N	10
5	Physician: The le r this certificata hes erel director, paga 2	o Be	exeminer?	to medicar	Hospital:	patient 2 🗆	ED/Outer	tient 3 D	Ot Ott	har	eth (Check only o				
0	Attending Physician: ir death. ector: After this certifici by the funerel director,	n: To	27. Menner of Death		28e. Dete o	Injury	28b. Time		28c. Inju Wo	4 Li Nursing i	1	how injury occur		")	
o	th. : Afte	iệ Iệ	1 Neturel 5	☐ Pending investigation	,	, Dey Year)	Injur	У		ork? ]Yes 2∐No					
SIN	il or Attending P eftar death. I Director: After t d in by the funere	HC		Could not be datarminad	289. Piece (	of Injury - At ho	me, farm,	street, factor	ry, office		28f. Location (	Straat end Num	ber or Rura	Route Numb	er,
	s effa	Certification:	4 🗆 Homicide		buildin	g, atc. (Specif)	<i>'</i> )				City or Tov	vn, Stete)			
	To the Hospital or A within 24 hours eftar To the Funeral Direcompletely filled in b	edical (	29a. Cartifiar (Check only one)	Certifying Phy Medical Exam	ysicien: To the baseliner: On the baseliner	is of examinat	wladge, da tion end/or	ath occurred	d et the ti	ma, data and place oplnion, deeth occi	e, and due to the urred et the time,	ceuse(s) and m date end place,	annar as st	ated. the ceuse(s)	
	o the	Me	29b. Signeture end title	of certifier	ond mem	J. 31010U.		29	c. Licens	se number		29d. Date signe	ed (Month. I	Day, Year)	
	F > F 0		Dani.	IR.K.	land	M.D			0.	31011			1		
		-	30. Nama and eddress	of person who	completed cause	of death (Item	23a) /Tvr	e Print)	DA	FUID R	· KAFOR	15K	1111		
			SUITE	301		751	FAZ	LLS	RD	TI	MONIUN	n M	D.		
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EDWARD FORD, JR.



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 21023

					Cei				Reg. I			
Dhuais	25	1. Decedent's Name (First, Middle	e, Lest)					2. Dat	e of Deeth	Nav.	Vene	3. Time of Deet
Physici /Medio		Aurella Free	man					JUN		Day 10	Yeer 997	8:30 P:
Examir		4e. Fecility Neme (If not institution	n, giva straet and n	numbar)			4b. City, Tov	wn, or Location		c. County		
		PHYSICIANS MEMORIA	AL HOSPITAL	4			LAPL	ATA		CH	ARLES	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year Months Deys		24 Hrs. 8. Dat Min. (Mo	e of Birth onth, Day, Yea	arl	9. Birthp	lece (Stata or Fore
Director		216-88-3562	1□M 2∏F	75	Yrs.	WOTHING Deys	riours	Mar	ch 4	192	2 Vi	rginia
pud *		Usual Residence of Decedent  10a. State 10b. County		10c C	ity, Town or Lo	cation						
with the Maryland a or 28a-f show be notified at	ŏ		_								11	0d. Inside City Lim 1 ☐ Yes 2 ☑
the A	Director	Maryland Cha 10e. Street end Number	rles	N	anjemo							21
with with	늅					10f. Zip Code			10g. (	Citizen of V	Whet Coun	try?
seth w	Funerai	8780 Riversi 11. Marital Status		cadent Ever in L	16 40 1	2066		-1-0 (O 16 - M -	- N		.A.	and a Man
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irs aff	by	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced		Sive T	1	☐ Yes 25 No	Specify:			Specify	Whi	te
filed within 72 hours after deeth with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ant, the Medical Examinet mant be notified at	be	15. Deceden	t's Education		16e. Deced	ant's Usuel Occu	petion		16b.	Kind of Bu	usiness/Ind	
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2 5 E Z		Lorene Freem	an D	aughte	r San	ne as #	10					
		20a. Method of Disposition		20b. I	Place of Dispos	sition (Nama of patory or other pla	2001	Date	20c.	Location -	City or To	wn, State
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permit. Pages Depertment of important: If it any injury or once.		21. Signeture of Funerel Servica		Ival		Baptis Name and Addr			Nd	njem	oy,	Maryla
permit. Pages 1 and 2 should be filed within 72 hours aft Deportment of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examples.		12000	11	_ M00	660 V	Villiam	s Fun	eral H	lome,	P.A.		
		23e. Pert1. Enter the sease, or shock, or heert falling. List	complications that	caused the deal	th. Do not enté	270 Ha	wthor	ne Rd.	Indi	an H	lead,	Md. 2
Dhysisian	2 4	shock, or heart the unb. List	only one ceuse on	each line.	un. Do not onte	i the mode of dy	ing, such as c	arolac or respir	olory orrest,			Intervel Between Onset end Death
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Examiner		disease or condition resulting in death)	a C (	auto j	)WC W	00 10000	)		,		N	3. 130 111
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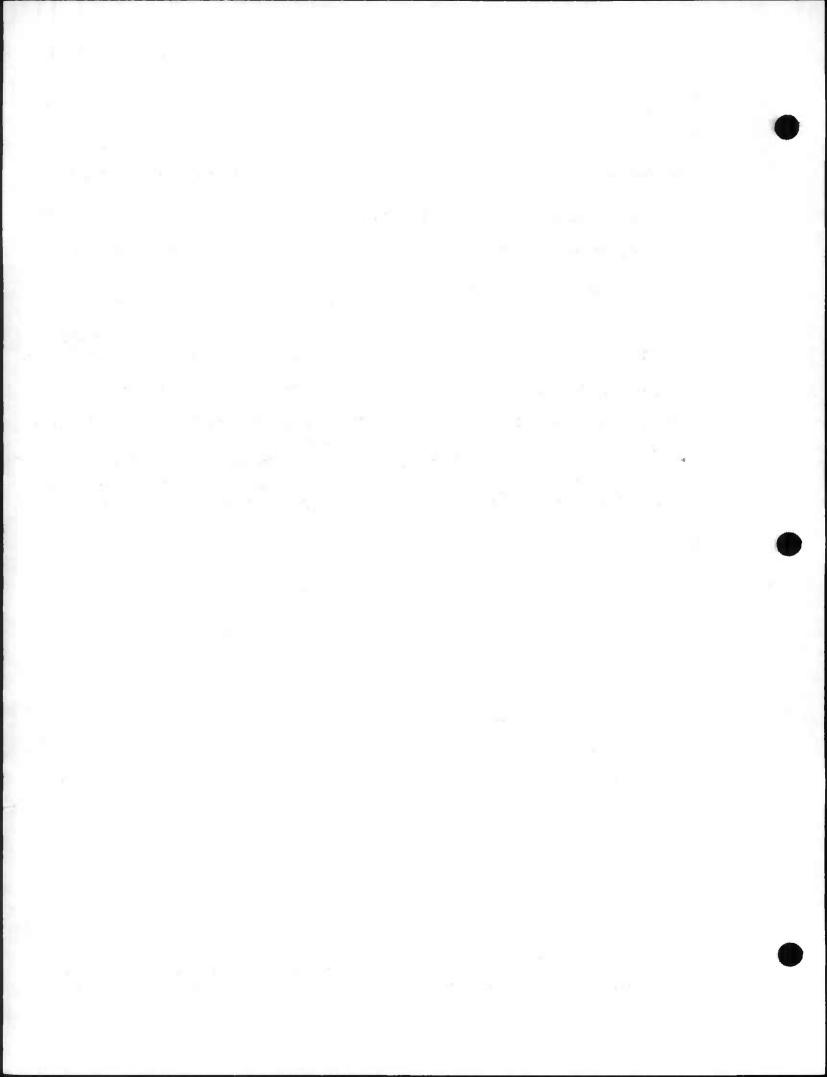
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 7 2 1 0 2 1

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Yaar RETTY FRECHETTE JUNE 24, 1997 12:32 P.M. /Medical 4a. Feclity Nama (If not institution, giva straet and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MALCOLM GROW MEDICAL CENTER CAMP SPRINGS PRINCE GEORGE'S If Undar 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 K Yrs. Director 508-48-5783 60 16,1937 England Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or Nems 23e or 28e-f show traumatic event, it a Medical Examinar maint be notified at Maryland Charles Waldorf 1 Yas 2X No Director 10e. Street end Number 10f. Zip Code 10g. Citizan of Whet Country? with 20601 3207 Pinefield Circle United States death Funeral 12. Wes Dacedant Evar in U,S. Armed Forces?
1 ☐ Yas 2 ☒ № Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) Race - American Indien, Bleck, White, etc. 11. Marital Status Peges 1 and 2 should be filed within 72 hours efter nent of Health and Mental Hygiene. In It Item 27 is marked other than "naturel", or ite my or other traumatic event, ITEM Medical Experient my or other traumatic event, ITEM Medical Experient. Maryland 21215-0020 If Yes, Give Yaar or Detes: Specify: White 1 ☐ Yes 2 ☐ MoX Specify: þ 3 ☐ Widowed 4 ☐ Divorcad 16b. Kind of Business/Industry 15. Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highast grada completed) Charles County Elementary/Secondary (0-12) College (1-4or 5+) 12 Board of Education Instruction Asst. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) Robinson Arthur Goodge Margaret 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Robert A. Frechette 3207 Pinefield Circle, Waldorf, Md 20601 altimore. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 20b. Place of Disposition (Name of Time 30, 19997 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Cheltenham, Maryland 22. Name end Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd, Clinton, Md Art1. Enter tha disease, or complications that caused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximeta Intarvel Betw **Physician** /Medical Immediate Ceuse (Final disaase or condition resulting in deeth) •ACUTE HEMORRHAGE OF ARACHNOID SPACE AND PARIETAL LOBE Examiner 1 DAY Due to (or es e consequence of): Examiner METASTATIC ADENOCARCINOMA OF THE BRAIN 2 WEEKS the death certificate be executed physician end s the buriel-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): METASTATIC ADENOCARCINOMA, UNKNOWN PRIMARY UNKNOWN Physician/Medical the Dua to (or as a consequenca of) for use es UNKNOWN CARCINOGEN UNKNOWN the t Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? signed by the 1 Yes 2 No 3 Probably 4 Unknown MULTIPLE LIVER METASTATIC LESIONS þ 24b. Wara autopsy findings eveilable prior to completion of causa of deeth? 24a. Wes en eutopsy performed? Completed peen MULTIPLE PLEURAL LESIONS BELIEVED TO BE hes 1 X Yes 1 ☐ Yes 2 🐼 No Division of Vital METASTATIC NEOPLASMS Attending Physician: funeral director, Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetiant 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 Netural
2 ☐ Accident 5 Pending To the Hospital or Attending within 24 hours after deeth.

To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No investigation 3 Suicide 6 Could not be 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Medical 1 Certifying Phyelcien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier 29b. Signature end title of certifiar 29c. License number 29d. Date signed (Month, Dey, Year) MO MD D48119 JUNE 24, 1997 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 89 MDG/1050 W PERIMETER RD SUITE C1-7 RICHARD BRANSDORF, MAJ, USAF, MC ANDREWS AIR FORCE BASE, MD 20762-6600 31. Dete filed (Month, Dey, Year) 32. Registrar a Signature Randall State JUL 0 2 **199**7 Registrar



MES	5 I	te	m:5 per FH G-749 7/16	State of M	/laryland	Department		l Mental Hygi	ene		
SS .	ı te	ems	m:5 per FH G-749 //16:23a part I,27,28a-f 1. Decedent's Name (First, Middle, I	per MEU G-/4	9 7/14/97	Certificate	of Death	2. Date of Death			Time of Death
Physi			JAMES MICH	AEL GASS				JUNE	Day 2.8 1	Year 997 10	:30P.M
/Med Exam			4a. Facility Neme (If not institution, g	rive street end number	r)		4b. City, Town, o	or Location of Death	4c. County		:SUP.M
			143 FAIRVIEW A				KINGST			EN ANNE	
Funera Directo			5. Social Security Number 6 718-40-2765	Sex 7. A	age (In yrs. lest b 4.7	Yrs. If Under 1 \ Months D	ear If Under 24 H ays Hours Mi	in. (Month, Dey,			(State or Foreign
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itel Hygiene. Id other than "netural", or items 23e or 28e-f show event, the Medical Examiner must be notified at	Ι.		10a. State 10b. County			wn or Location				10d. In	slde City Limits
9		Ş	Md. Queen	Anne's	King	stown				1	☐ Yes 2 <b>∑</b>
or 28	1	Director	10e. Street and Number	7		10f. Zip Co	de	10	g. Citizen of	What Country?	
23e	-	ā	143 Fairview	Ave.			21620		U.	S.A.	
E B		Funerai	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U,S.	13. Was Deceden	of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No-		ce - American Inck, White, etc.	dian,
P F	ď	3	1 Never Married 2 Married			1 ☐ Yes 2 🔀		orto i nodri, otc./		y: White	,
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arke artic	F	္	George Gass				нет	en Hilar	У		
Department of Health and Mentel Pimportent: If Item 27 is marked out eny injury or other traumatic ever			19a. Informant's Name/Relationship			b. Mailing Address (S			-		
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To the Hospital within 24 hours To the Funeral completely filled

29b. Signature and title of certifier

Nonald Ly Wing WMD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Yeer) 29c. License number

> O.C.M.E. JUNE 29,1997

DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201

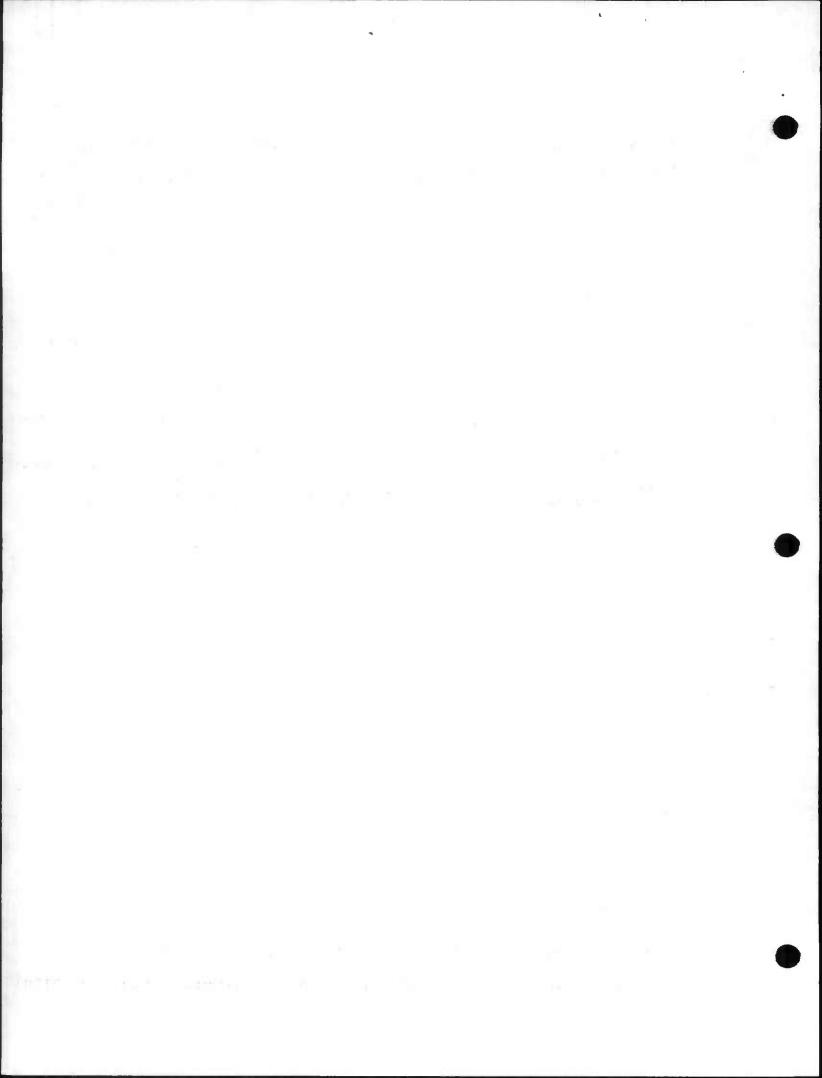
State Registrar

31. Date filed (Month, Day, Year)

JUL 1 0 1997

32. Registrar's Signature

Fishia Sairdon-Rindell



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						Cer	tificate of	Death		R	leg. No.		
	-51		1. Decedent's Name (First, Middle, Le							Date of Dee	th		3. Time of Death
l	Physic /Medi		MARY MA	EDFLINE	Gil	ひしゴ	DRING	G		Month June 2	28 1997	Year	12:19 PM
	Exami		4d. Fecility Name (If not institution, give					4b. City, Tow	n, or Locatio	on of Death	4c. Count	y of Deeth	
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ı	Director		218-26-5719	1□M 2□XF	59	Yrs.	Months Days	Hours	OC	Pate of Birth Month, Dev CT 5 1	927		land
	D .	7	Usual Residence of Decedent  10a. State 10b. County		o- Ob- T-								
	sho	<u>_</u>		'	Oc. City, Tow		cation					1	10d. Inside City Limits
	he M	Director	Maryland Charles		Wald	OFI							1X Yes 2□ No
	Mith of the		10e. Street end Number				10f. Zip Code			1	0g. Citizen of		ntry?
	s 23	era	3012-A Palmer Plac			1		602			1	USA	
	in 72 hours effer death with the Maryland "natural", or flems 23a or 28e-f show fedical Examinar must be notified at	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U,S.	13. V	Vas Decedent of Yes, specify Cu	Hispanic Origi ben, Mexicen,	n? (Specify Puerto Rica	Yes or No- n, etc.)		ce - Americ ick, White,	
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P	offied offied officer	Be C	17. Father's Neme (First, Middle, Last)					18. Mother	s Name (Fin	st, Middle, I	Meiden Surnar	ne)	
/lai	should be filed withing and Mental Hygiene.  s marked other than umatic event, the Mental count, the Mental count	ToE	Robert P. Butler					E11	a R. S	Shade	Butler		
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	and Salth		Mary T. Morman (1	Daughter)	4	922	Megan I	rive C	lintor	n, MD	20735		
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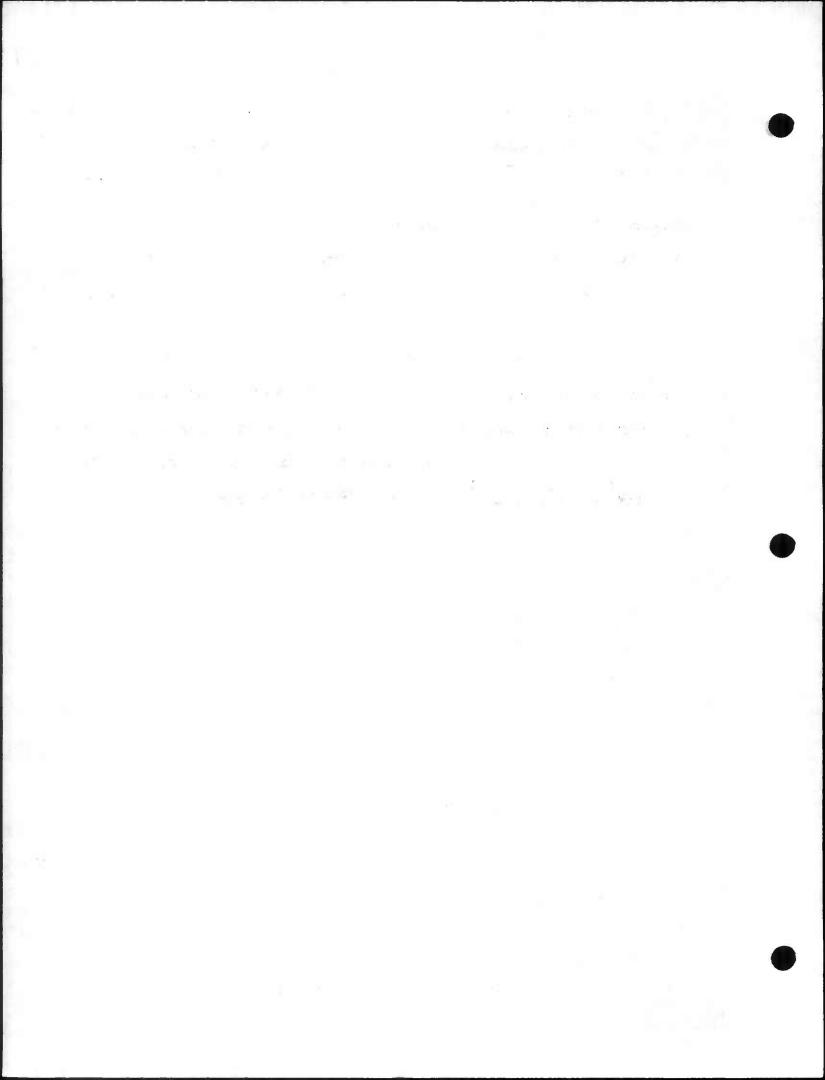
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State of Maryland / Department of Health and Mental Hygiene

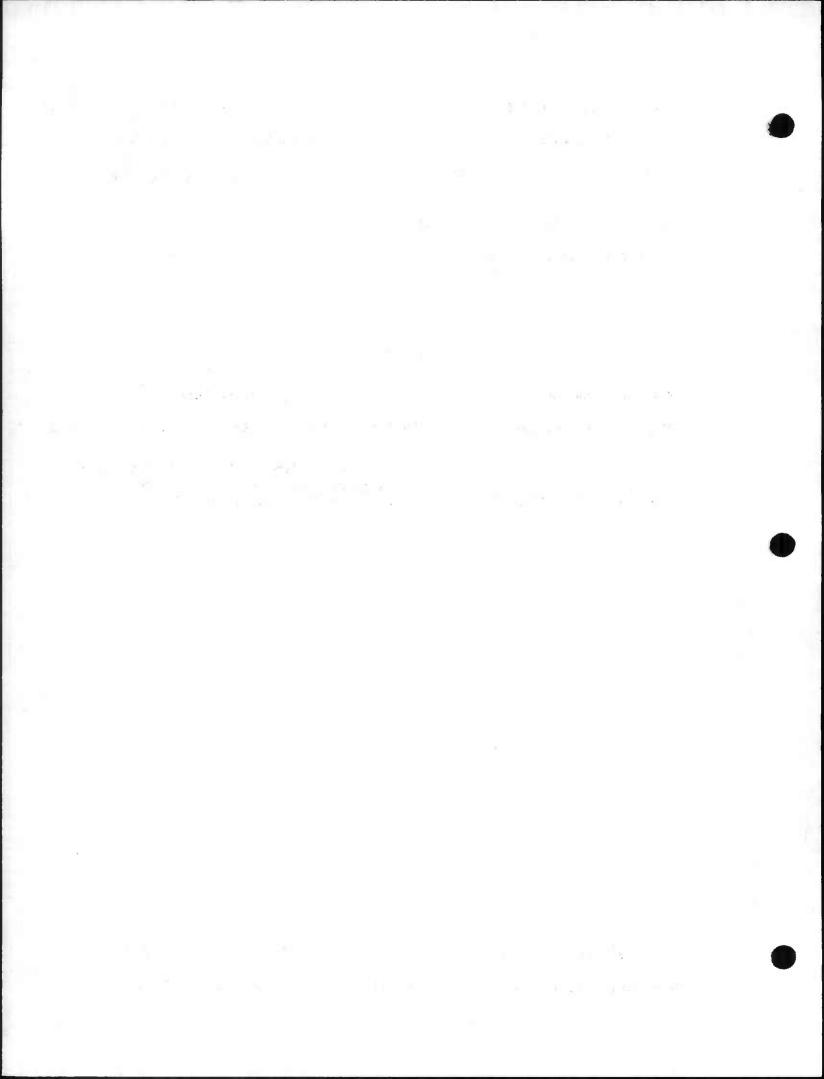
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-				6. Sex	7. Age (In yrs.	last hirthday)	If Und	er 1 Year	If Under 24 Hrs				an /Otata as Foreign
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			30. Neme end eddress of person wi	no completed caus	e of death (Item	23e) (Type.	Print)						
			Krishan Math	ur, M.D	P.	O. B	OX	2729	, La P	lata, M	4D 20	)646	
	Sta	te	31. Dete filed (Month, Day, Year)	32, R	eistrer's Signat	ure							
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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 21028

						Ce	rtificate	of	Death		F	leg. No.			
			1. Decedent's Neme (First, Middle	Last)					<u> </u>	1	2. Dete of Dee	th	Vac-	3. Time	e of Death
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	amin		4a. Fecility Neme (If not institution,	give street and numb	ber)				4b. City, Tow	vn, or Loca	ation of Deeth	4c. County	of Deeth		
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1)			Mark Henderso	n, M.D.	(	600 Mc	akley	St	. Leon	ardt	own, MI	20650	)		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 4:50 A.M. CHARLES JOHNSON GILL, JR. June 21, 1997 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CONVALESCENT REHABILITATION Ctr. GOLDEN OAKS Laural Prince George's If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Deys 113M 2□ F 60 Yrs. Director Sept. 6, 1936 577-44-9516 Washington, D.C. Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1KIYes 2 □ No Director District of Columbia Washington 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 "natural", or items 23a 5119 Sheriff Road, N. E. United States 20019 Funeral 12. Was Decedent Ever In U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mentel Hygiane. Important: If Itam 27 is marked other than "natural", or itam any injury or other traumatic. 1√2 Yes 2 No If Yes, Give 10/4/55 Year or Dates: 10/3/50 1 □ Never Married 2 □ Married 1 ☐ Yes 2 Ø No Specify: p Specify: 3
☑ Widowed 4 ☐ Divorced Black 10/3/59 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Private - PEPCO 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Charles Johnson Gill, Sr. Aver W. Hunter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia J. Gill - Sister 5046 Sheriff Road, N.E., Washington, D.C. 20019 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National Memorial Park 6/25/97 Laurel, MD 21. Signature of Funeral Service Lies 22. Name and Address of Facility STEWART FUNERAL HOME, INC. 4001 Benning Road, N.E., Washington, D. C. 20019

11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximete Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Months uns Cancer disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner The law requires thet the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) physicien Physician/Medical the Due to (or as a consequence of). Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? á 120 Yes 2 □ No 3 □ Probably 4 □ Unknown Dehydrathoz signed I þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed pega 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificata Hospital or Attending Physician: 24 hours after deeth.
Funaral Diractor: After this certifica etely filled in by the funeral director, g Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Medicai Certification: To 1 Yes ≱€No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Dev Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated. 29a, Certifier 29b. Signatule end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 0 June 24, 1997 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) MD14333 Lawel Eure Kd 7307 Lawel MD 20708 4 Mon

State Registrar Date filed (Month, Day, Year)

32. Registrar's Signeture

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Year **Physician** Delores Jean Groomes 4b. City, Town, or Location of Deeth 4c. County of Deeth /Medical 6:25p.m. 4e. Fecility Name (If not institution, give street end number) **Examiner** Doctor's Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1□ M 2X F Deys Hours Director Yrs 577-40-6914 64 1932 Washington, DC Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28s-f show other traumatic event, the Medical Examinar must be notified at 1⊠Yes 2□No Director Maryland Prince George's Riverdale 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4917 Nicholson Street 20737 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel, or items 23s any injury or other traumatic event, the Medical Examinar mass. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Rece - American Indien, Black, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Merried 2 N Married 1 ☐ Yes 2 🖾 No ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be e Wallace W. Cook Fannie Stables 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Jacob Groomes, Sr. - Husband 4917 Nicholson Street, Riverdale, Maryland 20737 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Cemetery 06/23/97 Brentwood, Maryland 22. Name end Address of Fecility
Francis Gasch's Sons Funeral Home, P.A. 21. Signature of Funeral Service Licensee d. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Betw **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Weel2 Examiner Examiner physiclen and s the buriel-transit Sequentielly list conditions, if eny, leading to Immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Lest Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as e consequence of) signed by the atte Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? been si 24a. Wes en eutopsy performed? Completed hes 1 Tyes 2 No 1 ☐ Yes 2 ☐ No I or Attending Physicien: after death. Director: After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpetient 3 DOA 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital or within 24 hours af To the Funeral DI edical 29a. Certifier Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es steted. Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) and menner steted. 29b. Signeture end title of certifier 29d. Date signed (Month, Dey, Yeer) 29c. License number Bowie MD 30. Name end eddress of person who completed cause of de 31. Dete filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

JUN 23 1997

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2 1 0 3

Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Death **Physician** June 18, 1997 Theresa A. Garnavich 9:40 P.M. /Medical 4b. City, Town, or Location of Death 4a. Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner 14209 Masterpiece Lane Potomac Montgomery If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Yeer)

Jan. 21, 1919

9. Birthplece (Stete or Foreign Country)
Michigan 5. Sociel Security Number 7. Aga (In yrs. lest birthday) 8. Data of Birth (Month, Dey, Yeer) **Funeral** Days Hours 1 □ M 2 🕅 F 379 16 7001 Director Yrs. 78 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural, or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Xas 2 No Director Maryland | Montgomery Potomac 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 14209 Masterpiece Lane 20878 United States death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 12 No If Yes, Give Yaar or Detes: Was Dacedant of Hispenic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or her any injury or other traumatic event, the Medical Evant Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorcad Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Registered Nurse Hospital 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumame) Be Antonio Battuello Caroline Demarie P 19a. Informent's Name/Relationship (Typa, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Patricia A. Sylvia Daughter 14209 Masterpiece Lane Potomac Maryland 20b. Place of Disposition (Nama of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Lakeview Cemetery 6/23/97 Calumet Michigan 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signat ure of Funeral Service Licensee 22. Name end Addrass of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 23a. Part1. Enter the disease, or complication, hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feilure. List only one carries on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final LIVER METASTASIS diseese or condition resulting in death) Examiner Examiner ADENO CARCINOMA OF UNKNOWN PRIMARY physician end s the buriel-transit Sequentielly list conditions, if eny, laading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieled events resulting in death) Lest Due to (or as e consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of): signed by the et d be deteched fo Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24e. Was an eutopsy performed? 24b. Ware autopsy findings eveileble prior to Completed completion of causa of death? certificate hes 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Wes case referred to medical 26. Plece of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyeiclan: To the best of my knowledge, death occurred et the time, dete end placa, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end menner stated. 29a, Certifier 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D 50308 18,1997 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) BETTHERDA, MD

NNMC, 8901 WISLONSIN AVE BLOCE RMSION

State Registrar 31. Date filed (Month, Day, Year)

JUN 24. 1997

33 Registrar's Signature

JAMES E. BUTRYNSKI.

Emple The sine SHE OF HOL

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Certificate	e of	Death		Reg. No.		-1002
	Physic	ion	1. Decedent's Nama (First, Middle, Le	-					2. Dete of D	eth	Yeer	3. Time of Death
	/Medi		Margaret Louise	Garrison					June	23, 199	7	2:00 a.m
	Exami		4e. Fecility Name (If not institution, giv					4b. City, Town, or	Location of Dee	th 4c. County	of Death	
1			7415 Allison St					Landover				orge's
	<ul><li>Funeral Director</li></ul>		5. Sociel Security Number 6. S 217-14-6742 1  Usual Residence of Decedent	Sax 7. Aga □M 2[X]F	76	Yrs. If Undar Months	1 Year Days		(Month, D	rth ay, <i>Year)</i> 17, 1921		placa (State or Foreign ntry) yland
	yland		10a. State 10b. County		10c. City, Tow	n or Location						10d. Inside City Limits
	with the Maryland a or 28a-f show be notified at	rector	Maryland Prince G	eorge's	Landove	er Hills	Code			10g. Citizen of V	What Cou	1 ∑ Yas 2 □ No
	death with ms 23a or	Funeral Director	7415 Allison Stre			207	84			U.S.A.		
21215-0020	urs efter al', or ite	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:		13. Was Deceded If Yas, special 1 Yes 2		Hispenic Origin? (S an, Mexicen, Puer Specify:	to Rican, etc.)	Specify	k, Whita,	can Indien, atc. ite
5-0	n 72 hours "natural",	etec	15. Decedent's Ed (Spacify only highest gre	ducation da completed)	16e.	Decedent's Usuel (Give kind of work	t Occu k done	pation during most of wo	rkina	16b. Kind of Bu	ısiness/In	ndustry
121		Completed	Elementery/Secondary (0-12)	College (1-4or 5-	+)				9	DO T		0
	Hygid Hygid Ther ant,	ပိ	17. Father's Nama (First, Middle, Last)		5%	ritchboar	a		me (First, Middle	DC Trai		Company
Maryland	id be ental ked c	To Be	Richard Anderson					Carrie			-/	
ary	shound M	-	19a. Informent's Name/Relationship (		19b	. Mailing Address	(Stree	t end Number or R			State. Zir.	Coda)
	alth e		Margaret L. Royer	- Daughte	_							yland 20784
Baltimore,	permit. Peges 1 end 2 should be filed within Department of Health end Mental Hygiene. Important: If Item 27 is marked other than any folury or other traumatic event, Ite M ance.		20e. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐		20b. Place of cemeter	Disposition (Nem y, cremetory or oth	e of har pla	ce)	Date	20c. Location -	City or To	own, State
Itin	It. Pertrant		4 □ Donetion 5 □ Other (Specif)  21. Signeture of Funerat Servica Licen	<u> </u>	Fort			etery (	06/25/97	Brentwo	od,	Maryland
Ba	Depa Impo any ir		P. Signeture of Parietal Service Elder	•			Ga	sch's So				
$\ell_{\blacksquare}$	-		23a. Pert1. Enter the diseasa, or com- shock, or heert failure. List only	plications thet caused	the death. Do i	4739 Ba	lti of dyi	more Ave	nue, Hya	attsville orrast	e, M	
	Physician		shock, or heert failure. List only	one ceuse on each tine	Θ.		,			,		Approximete Interval Between Onset end Deeth
웹	/Medical		tmmadiate Ceuse (Final disease or condition	Gerel	oro vas	cU/2~	A	cade	1-			comedial a
ĸ.	Examiner		resulting in deeth)		Due to (or es e	consequenca of):					1	Kears.
	pe #s	line		Atrie	el fibi	-1112ron	7				1	years.
, 0	intificete be executed ing physician end e es the burial-transit	Examiner	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or trijury	C	Due to (or es e	consequence of):						
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Box 6	nding p			d								
	death e ette ed for	sicia	Pert II. Other significent conditions of	ontributing to death but	t not resulting In	the underlying ca	use di	ven in Part I	23h Did	tobacco use con	tribusta t	o the cause of death?
P.O.	thet the ed by th deteche	/ Physician/			, rock too and any	and and anything ou	aso g.	TOTAL CITY		Yes 2 No		bably 4 Unknown
of Vital Records,	lew requires that the death certificete be executed res been signed by the ettending physician end a 2 should be deteched for use es the burial-transit	Completed by							24e. Wes	en eutopsy ormed?	ev	ere autopsy findings ellable prior to impletion of cause deeth?
	ysician: The lev s certificate hes director, page 2	Con							10	Yes 2 No	1[	☐Yes 2☐ No
/ite	Physician: this certific ral director,	Be	25. Wes case referred to medical exeminer?					26. Plece of Dea	ath (Check only	one)		
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	a fee	lon	27. Manner of Deeth  1 ☑ Neturat 5 ☐ Pending	28e. Dete of Injury (Month, Dey		njury	kc. Injui		28d. Describe	how Injury occurre	ed	
Sic	or Attending effer deeth. Director: Affei in by the fune	Cat	2 Accident investigation 3 Sulcida 6 Could not be		n. Athama (a	M		Yes 2 □ No	Opt I pestion /	Ctua at a and the are		1 Dente Atlanta
Division	7 4 5 5	Certification:	4 ☐ Homicide determined	28a. Pleca of Injur building, atc.	(Specify)	m, street, factory,	OTICE		City or To	Street end Numbe wn, Stata)	er or Hurs	ar Moute Number,
	To the Hospital or Attent within 24 hours efter deet To the Funeral Director: completely filled in by the	edical (	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	valcien: To the best of iner: On the basis of e	examinetion end	deeth occurred at Vor Investigetion, i	t the tir	ne, dete end place plnion, deeth occu	, end due to tha rred et the time,	ceuse(s) end mei date end placa, e	nner es s	teted. o the cause(s)
	To the To the Comp	Σ	29b. Signeture and fitte of certifier	10				e number		29d. Date signed	(Month,	Dey, Year)
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(	4/		30. Neme end address of person who c						**			007/0
	Sta	te	Dennis A. Cullen, 31. Dete filed (Month, Dey, Yeer)	32 Registrer	's Signature		enu	e, Marlov	7 Height	s, Maryl	and	20748
1	Registr		JUN 25 1997	Jak de	witerle	ball						

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Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Yeer **Physician** GROSE Month 35 MILDRED 97 6 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Snow Hill Nursing & Rehab LenTer WORCESTER SNOW HILL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 9. Birthplece (Stet Country)
April 20, 1905 Maryland 5. Social Security Number Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Deys 1□M 2ÃF 579-18-6267 Director 92 Usuel Residence of Decedent the Merylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f shore the Medical Exerciper must be notified at 1 ☐ Yes 2 No Directo Maryland Prince George's Hyattsville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? filed within 72 hours efter death with 5608 Newton Street 20784 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: ò Specify: White 3 Noticed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry National Elementary/Secondary (0-12) College (1-4or 5+) Hygiene permit. Peges 1 end 2 should be filed v Department of Heelth end Mentel Hygiel Important: if item 27 is marked other th any injury or other traumetic event, the Teacher & Businesswoman Security Agency 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be John Selby Holston Sally Clark Holston 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Sam Keiffer - Son 8930 Harmony Court, Owings, Maryland 20736 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 🕅 Bunel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Cemetery 06/26/97 Brentwood, Maryland 22. Name and Address of Fecility
Francis Gasch's Sons Funeral Home, P.A. 21. Signeture of Funeral Service Licensee 4739 Baltimore Avenue, Hyattsville, MD 20781 ence 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. **Physician** Immediete Ceuse (Finel diseese or condition resulting In deeth) /Medicai LSSENTIAL HYPERTENSION 5 YEARS Examiner Due to (or es e consequence of) Physician/Medical Examiner lew requires that the death certificate be executed physiclen end s the buriel-trensit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Records, P.O. Box 68760, Due to (or es e consequence of): 88 attending Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by 1 Yee 25 No 3 Probably 4 Unknown ģ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy peed 2051ER 18S certificate ! 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 28. Place of Deeth (Check only one) Hospitel: 2 1 Yes 2 No Other: Thursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 27. Manner of Deeth 28a. Date of injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After t 1 Panaturai 5 Pending investigation deeth. within 24 hours efter deeth.

To the Funeral Director: A
completely filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide the Hospital 1 Certifying Phyelclen: To the best of my knowledge, deeth occurred et the time, date end pleca, and due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end menner stated. 29e. Certifier edical (Check only one) within 2 29b. Signeture end title of certified 29c. License number 29d. Date signed (Month, Dey, Year) 2 D 06241 6-22-97 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) M.D. 203 SNOW ST. , SNOW HILL, NO. 21863 40LZWOP 31. Date filed (Month, Day, Yeer) 32. Registrer's Signeture State **JUN 25** Registrar

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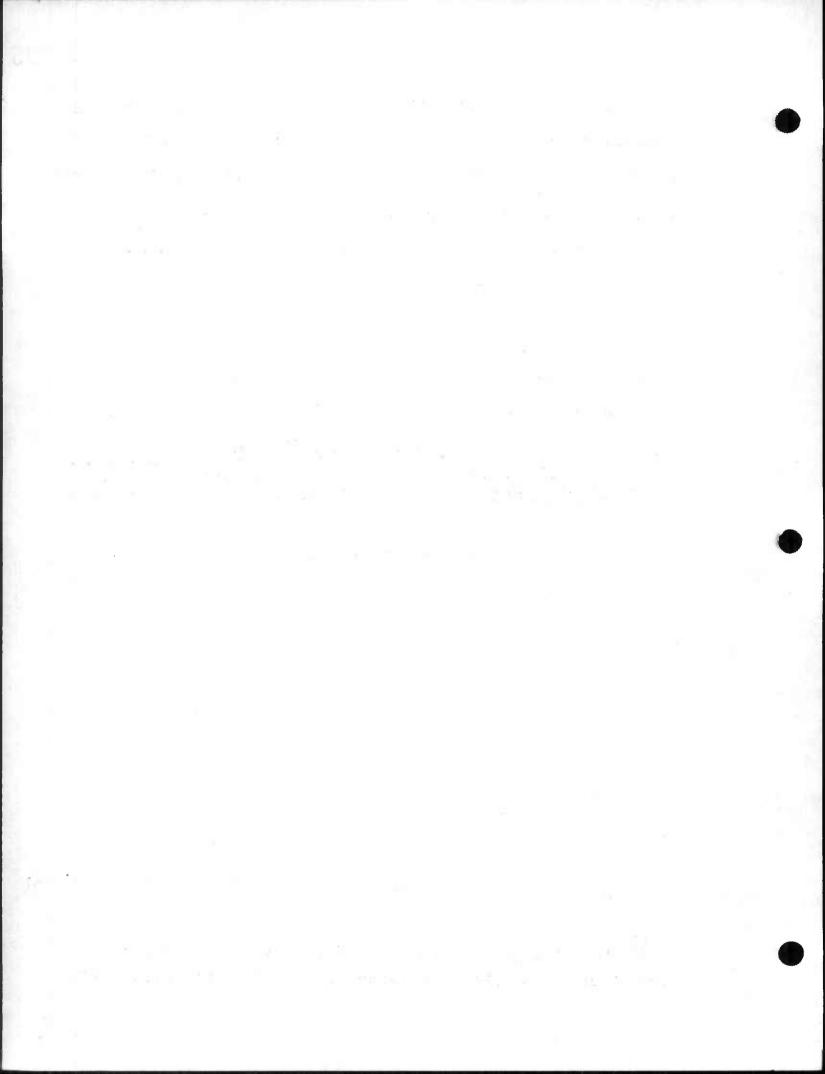
### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 21034

						Cer	rtificat	e of	Death		R	eg. No.		
			1. Decedent's Name (First, Middle, La	_								3. Time of Deeth		
	Physician /Medical		Paul Grover Garver								June	23 Day	1997	5:40AM
	Examir		4e. Fecility Neme (If not institution, giv-	e street end number)		4b. City, Town, or		wn, or Lo	ocation of Deeth	4c. County	of Deeth			
Ĺ			Northampton Mano	r Nursing	sing Home Fre			eder	rick F			lerick		
	Funeral		Sociel Security Number     6. S		(In yrs. last bir	thday)	If Under				8. Dete of Birth	Vees	9. Birthpl	lece (Stete or Foreign
L	Director	by Funeral Director	219-10-8120	XM 2□ F	75	Yrs.	Months	Deys	Hours	Min.	(Month, Dev. Sept. 3	, 1921	Man	lece (Stete or Foreign try) ryland
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	how 1 at		10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits											
	e Me		Maryland Carrol	1			Union	ı Br	ridge					1 ☐ Yes 27⊠ No
	or 28		10e. Street end Number 10f. Zip Code 10g. Citizen of Wh									try?		
	23a										S.A.			
	r deg		11. Marital Stetus	12. Wes Decedent E Armed Forces?	ver in U,S.	13. V	Wes Deced	ent of	Hispanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)		e - America	
20	or it		1 ☐ Never Merried 2 ☐ Married	1 XXYes 2 □ No If Yes, Give	0		1□ Yes 2				, , , , , , , , , , , , , , , , , , , ,	Specify		
Ö	ural',		3 X Widowed 4 □ Divorced	Vidowed 4 □ Divorced Yeer or Detes:			16e. Decedent's Usuei Occupation						VV 11 1	
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Maryland	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	To Be	17. Fether's Neme ( <i>First, Middle, Last</i> ) Guy Garver					18. Mother's Name (First, Middle, Meiden Sumeme) Sadie Rippeon						
Ë	2 should be filed within 72 hours after death with the Maryland and Mentel Hygiene. It marked other than "natural", or items 23s or 28s-f show raumatic event, the Medical Examples must be notified at		,											
Ma	s 1 and 2 should f Health and Mer tem 27 is merks other traumatic		19e. Informant's Name/Reletionship (1888)  Betty J. Boone/ d								el Route Number			
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altimore,	Peges nent of I nrt: If ite iry or o		1 ☑ Buriei 2 ☐ Cremetion 3 ☐	Removel from Stete	cemeter	y, crem	netory or of	ther ple				20c. Location -		
t T	It. Perutinguity		4 □ Donation 5 □ Other (Specify	~ /	Locust						5/25/97			y, MD
Ba	permit. Peges 1 and 2. Department of Health at Important: If item 27 is any injury or other trau		21. Signature of Funeral Service Licer	$\neg (\chi \zeta)$	DO.	22.	. Name en	d Addr	ess of Fecilit	<sup>y</sup> Har	tzler Fu	ineral H	ome	
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			23a. Pert1. Enter the disease, or complications that caused to deeth. Do not enter the mode of dying, such as cardiec or respiretory errest,  Approximate intervel Between											
	Physician		Onset end Deeth											
	/Medical Examiner	ш	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Character pulm disease years											
		Examiner	Due to (or as a consequence of):  Change of the consequence of the con											
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Vital	ysician: The		25. Was case reterred to medical examiner?	Honoitol.				0.	. /	of Deet	h (Check only on	θ)		
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S	tend Jeath tor: /	cat	2 Accident Investigation M 1 Yes 2 No 3 Suicide 6 Could not be											
DIVISION	I or Attanding Physician: effer death. Director: After this certific d in by the funeral director,	틭	28e. Place of Injury - At home, ferm, street, tectory, offica building, efc. (Specify)  28f. Location (Street end N City or Town, State)									iber or Rurel Route Number,		
_	To the Hospital or Attanding F within 24 hours effer death. To the Funeral Director: After completely filled in by the funer		29e. Certifier 12 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.											
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			30. Name end eddress of person who o					M+	A + ~ -	, MI	D 21771			
	- 240	to	Ronald E. Mill 31. Date filed (Month, Day, Year)					HL	. 411)	, (1)	21111			
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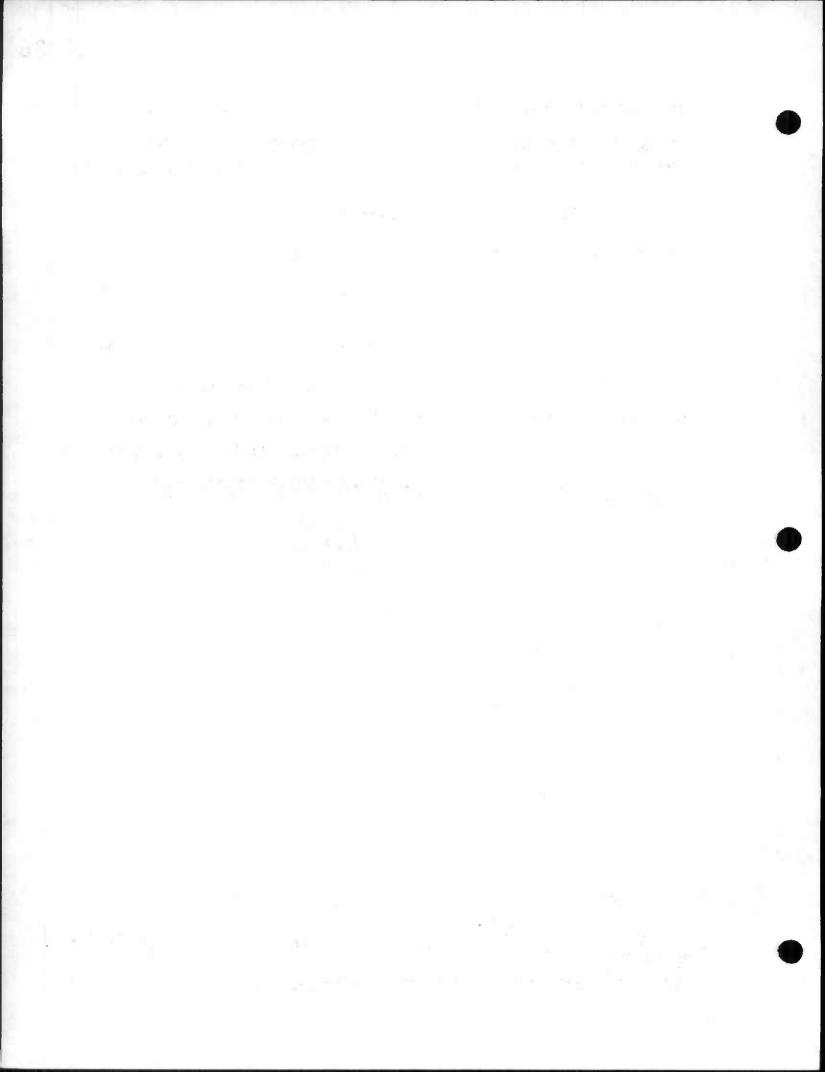
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Exami	iner	4e. Facility Nama (If not institution, giv	a straat and number)			4b. City, Town, or L	ocation of Death	4c. County of	Death		
		Southern Maryla				Clinton		Prince	George's		
Funeral Director		5. Social Security Number 6. S 212-20-5554 Usual Rasidance of Decedant	ax 7. Aga (In yrs. In the second of the sec	last birthday) Yrs.	If Under 1 Yaar Months Days		8. Date of Birth (Month, Day) April 1	Year)	9. Birthplace (Stata o Country) Washingtor	r Foraign	
larylend ahow	o.	10a. Stata 10b. County Maryland Prince G		y, Town or Lo					10d. İnsida Cit		
th the N or 28a-f	Director	10e. Street and Number		TITICOIT	10f. Zip Coda		1	0g. Citizan of Wh	net Country?	212140	
sath w	erai [							U.S.A.			
permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.	by Funeral	11. Marital Status  1∑Navar Marriad 2☐ Married 3☐ Widowed 4☐ Divorced	12. Was Dacadant Evar in U, Armed Forcas? 1 □ Yas 2 ∑ YQ If Yas, Give Yaar or Datas:		was Decedant of I Yas, specify Cub I □ Yas 2∑ No	Hispanlc Origin? (Spean, Maxican, Puarto Specify:	Dacify Yas or No- Dican, etc.)		Amarican Indian, Whita, atc. White		
in 72 h n "natu Vedical	Completed	15. Decedant's Ed (Spacify only highast gra	da com <i>platad)</i>	16a. Daced (Giva	lant's Usual Occu kind of work done OO NOT usa ratire	pation duning most of work	king	16b. Kind of Businass/Industry			
led with lygiene ner tha	Com	Elementary/Secondary (0-12)	N/A (1-4or 5+)	N/.				N/A			
d 2 should be filed within 72 hours eft th and Mental Hygiene. 7 is merked other than "natural", or traumatic event, the Medical Exam	To Be	17. Fathar's Nama (First, Middle, Last) Fortunto Gioffre			18. Mothar's Name (First, Middla, Maiden Sumama) Maria Briggnti						
end 2 sho salth and I n 27 is me		19a. Informant's Nama/Relationship ( Josephine Boer	tlein (Sister)			and Number or Ru ane Dunki					
it. Pages 1 er rtment of Hea rtant: If Item?		20a. Method of Disposition 1 ∰Burlal 2 ☐ Crametion 3 ☐ 4 ☐ Donation 5 ☐ Othar (Spacifi	Ramovel from Stata Mt.	emetery, cram	sition (Nama of natory or other pla t Cemete	ery June 2		20c. Location - Ci Jashingto	on, D.C.		
Depermit Depermit Important Insportant Inspo		21. Signature of Fundral Service Liced	tour Jack			ass of Facility Lee Lexandria			Inc. on, MD2073	35	
Physician		23a. Parft. Enter tha disaasa, or com shock, or haart lailura. List only	plications that causad tha death one causa on each line.	. Do not anta	ar tha moda of dy	ng, such as cardiac	or raspiratory arre	est,	Approximete Intervel Baty Onsat and D	ween	
/Medical Examiner	ı	Immediata Cause (Final disaasa or condition resulting in deeth)  Bilattol Prevancia 48h									
be sit	liner		b. <u>Se</u>	مندط	delice (i).						
icate be executed physician end s the burial-transit	Examiner	Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseesa or injury c.									
death certificate be executed e attending physician end ed for use as the burial-transit	/Medical	Cause (Disease or injury that initiated events rasulting in death) Last  Dua to (or as e consequence of):									
after d for u	clar	Det II Other similiant and distance					1				
es that the death certific igned by the attending p be detached for use as	/ Physician/	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.						23b. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2尺 No 3 ☐ Probably 4 ☐ Unknown			
aw requir as been s 2 should	Completed by						24a. Wes er perform		24b. Wara autopsy fit eveileble prior to complation of ca of death?	0	
는 흥용	Co						1□ Ya	s 2 No	1 □ Yas 2 🖺 I	No	
ysician: The scentificate director, peg	To Be	25. Was case ratarred to medicel axaminar?	44 - %				h (Check only on	a)			
Physician: rthis certific ral director,		ILI IAS ZUM NO		ER/Outpatiant	JU DOA		oma 5□Rasida				
ding Physin. In. After this of funeral dia	on	27. Mennar of Daath 1 Natural 5 □ Panding	(Month, Day Yaar)	28b. Tima of Injury	28c. Inju Wo		28d. Dascribe ho	w Injury occurrad			
tend leath tor: /	Certification:	2 Accident Invastigation N/A N/A M 1 Yas 2 No					NIA				
or At after of Direct		4 Homicida dataminad dataminad building, atc. (Spacify)					281. Location (Streat and Number or Rural Routa Number City or Town, Stata) 7501 Showatts Rd Clint				
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edicai C	29a. Certifiar (Check only  Check only  Ch									
To the Within To the comple	Mec	29b. Signatura and titla of certifiar	and mannar steted.		29c. Licans	sa numbar	28	d. Date signed (i	Month, Day, Yaar)		
		Vich E.	Herm	MD	5:	20986		6/24/	97		
		30. Nama and address of person who of Victor Herry ,	omplated causa of death Itam MD 9131 Pi	23a) (Type, P .scata	Print)	ad, RM 2					
Sta Registr	_	31. Deta filed (Month, Day, Yaar)  JUL 0 2 199	32. Segistraris Signati	ura Parda	Ц						

DHMH 16 Rev 6/95



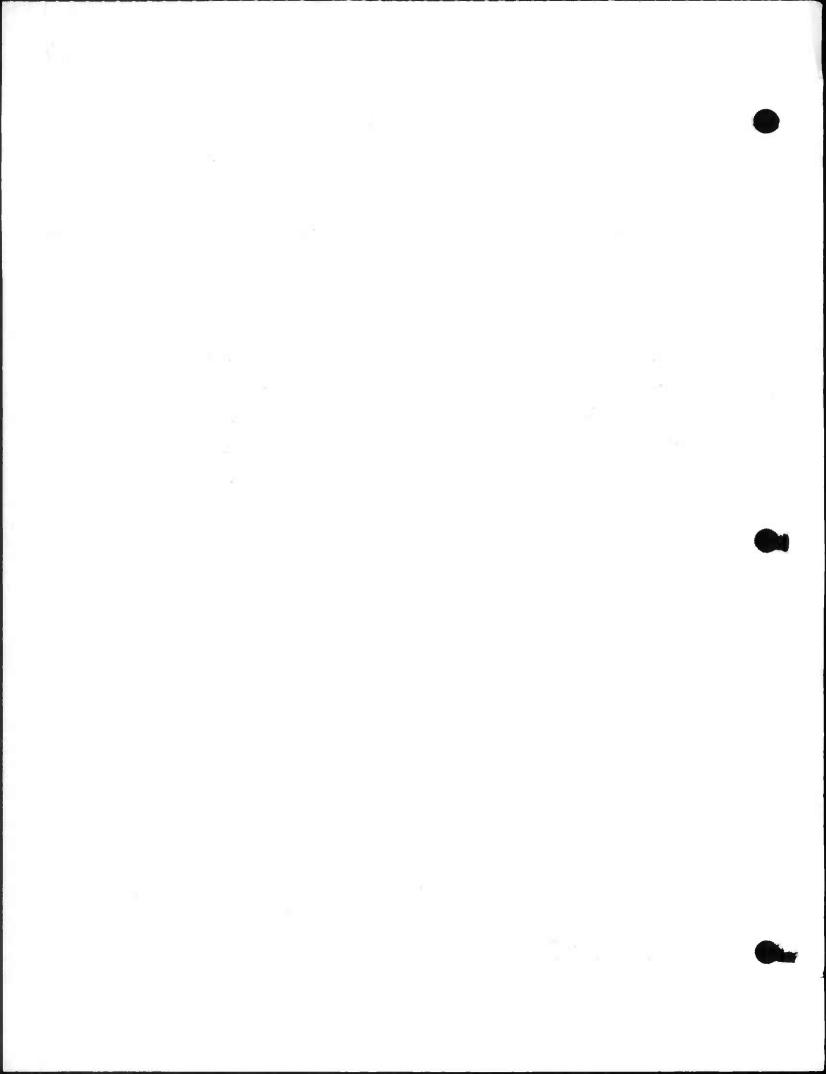
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			Ce	ertificate of	Death	Re	Reg. No.					
Dhuei		Decedent's Neme (First, Middle, Last)				2. Date of Deeth Month	1	3. Time of Death				
Physic /Med		Emogene Rice Green					Day 1997	1:50 A:M				
Exam		4e. Fecility Name (If not institution, give street and number,			4b. City, Town, or Lo	cation of Deeth	4c. County of D					
		PHYSICIANS MEMORIAL HOSPITAL			LAPLATA		CHARLES					
Funera Directo		407-22-7733 1□M 2⊠F	ge (In yrs. lest birthde) 81 yrs.	Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day Aug.	Year 1915	Birthplece (State or Foreign Country) Kentucky				
and and	tor	Usuel Residence of Decedent  10a. Stete 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits				
Manyl f she		MD Charles		Island				1 ☐ Yes 2 ☐ No				
ith the Marylan or 28a-f show	Je C	10e, Street end Number		10f. Zip Code		10	g. Citizen of Whet	21.				
with Sa or	ā	17719 Duvall St.			0.605	10		Country?				
daath ma 2	Funeral Director	11. Marital Stetus 12. Wes Decedent	Ever in U.S. 13.		0625 dispenic Origin? (Spe	cify Yes or No-	U.S.A	merican Indian,				
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiana. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Experimer must be notified at once.	þ	Armed Forces:  1 Never Married 2 Married 1 Yes, Give 3 Widowed 4 Divorced  Armed Forces: 1 Yes, Give Yeer or Dates:	No	If Yes, specify Cub  1 ☐ Yes 2 → No	dispenic Origin? (Speen, Mexicen, Puerto Specify:	Rican, etc.)	Black, W Specify: W	/hite, etc.				
5-0	Completed	15. Decedent's Education (Specify only highest grede completed)	18e. Deci	edent's Usuel Occup	petion during most of worki d)	1	6b. Kind of Busine	ess/Industry				
21 Eigin 21	npie	Elementary/Secondary (0-12) College (1-4or	5+) tife.	DO NOT use retire	d) most of work.	ng						
od w	Con	12	НО	memaker			Н	ome				
De fill	B	17. Fether's Neme (First, Middle, Last)			18. Mother's Name	(First, Middle, M	aiden Sumame)					
yla ould in Men mrke	ပို	Robert Rice			Edna Sh	ort Ric	e					
Aar 2 sh and is m		19a. Informant's Name/Relationship (Type, Print)			and Number or Rure							
and and and Tall Tall Tall Tall Tall Tall Tall Tal		Rebecca Dickerson			47 Cobb	Island,	MD 2062	25				
altimore, mit. Pagas 1 ar partment of Haa portant: if Itam 2		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)	Metropo	osition (Neme of ametory or other ple litan Ci	cem. 7/1	10-	Oc. Location - City Alexan					
Balt permit. Departr Imports any inj												
m 895 8 9		21. Signeture of Funerel Service Licensee  22. Name end Address of Fecility  AREHART-ECHOLS FUNERAL HOME, INC.  P. O. Boy 567 Lephanton MD 20646										
		MOO945 P.O. Box 567 LaPlata, MD 20646  23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.  Approximate intervel Between										
Physician		shock, or heert failure. List only one ceuse on each line.  Intervel Between Onset end Deeth										
/Medical	н	Immediate Cause (Final disease or condition resulting in death)  e. Authorized Vinderland Authorize										
Examiner												
71 - 5	ner	Haro	Join	AUS for	79m	Carper		XULAI				
8760, ata be executed hysician and the burial-transit	Examiner	Sequentially list conditions,	Due to (or as a conse	quence of):	7/2	^	1	" Your .				
0, e exe lan al		Sequentially list conditions, if ery, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that injuled events  Due to (or as a consequence of):  Due to (or as a consequence of):										
68760, ficata be ex physician as the burial	edicai	Cause (Disease or injury thet initiated events resulting in deeth) Lest  Due to (or as a consequence of):										
Box 68760, last certificate be executed attending physician and if for use as the buriel-transit	Mec											
BOX												
I Records, P.O. Bo) The law requires that the death of the has been signed by the attend page 2 should be deteched for us.	Physician	Pert II. Other significant conditions contributing to death b	en in Pert I.	23b. Did tobacco use contribute to the cause of death?								
P.O. hat the de detached datached	Phy						1 Yes 2 No 3 Probably 42 Unknown					
S, Fe es that igned be da	6											
of Vital Records, Physician: The law requires th this cartificata has been signer	Completed					24e. Wes en	eutopsy 24	b. Were eutopsy findings eveileble prior to				
aw ra be 2 sh	pie			· · · · · · · · · · · · · · · · · · ·		portorni		completion of cause of deeth?				
I Re The lav ata has paga 2	E					1 ☐ Yes	2 XNo	1 ☐ Yes 2 ☐ No				
	Bec	25. Wes case referred to medical			26. Plece of Deeth		,	10100 2010				
of Vita Physician: rithis cartification or all director,	To B	examiner?  1 Yes No Hospitel: 1 Inpatie	nt 2 ER/Outpetie	nt 3 DOA Oth	er.			naciful				
Phys ar this eral di		27. Megner of Deeth 28e. Dete of Inju		☐ Residence 6 ☐ Other (Specify) scribe how injury occurred								
Division  or Attending after death.  Director: After	atio	1 Naturel 5 Pending (Month, De) 2 Accident investigation	Year) Injury		28c. Injury et Work? 28d. Describe how injury occurred							
Visio Attendi	FIC	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury	2	28f. Location (Street end Number or Rural Route Number,								
Di safte	Certification:	4 Li Homicide building, etc	э. (Ѕреспу)			City or Town,	State)					
Division  To the Hospital or Attend within 24 hours after dealt To the Funeral Director: completely filled in by the	ai	29a. Certifier Certifying Phyeician: To the best of	of my knowledge, deat	h occurred et the tin	ne, dete end place, e	nd due to the ceu	se(s) end menner	es stated.				
2 2 2 2 2 2 3 2 3 3 3 3 3 3 3 3 3 3 3 3	edical	(Check only one)  2 Medicel Examiner: On the basis of end manner ste	examinetion end/or in	vestigation, in my o	pinlon, deeth occurre	d at the time, det	e end place, end o	lue to the ceuse(s)				
To the Committee of the committee of the	2	29b. Signature and title of certifier		29c. Licensi	e number	290	L Date signed (Mo	inth, (Qay, Xear)				
008N B		Draw (An last)		D-2	20629		6/2	919)				
		30, Name and address of person who completed cause of di	eath (Item 23a) (Tyne	Print)	A057000			11 /				
			etware comes experience		W 180 0000							
Str	te	GEORGE WATHEN MD 11345 PEMBROOKE 31. Date filed (Month, Day, Year) 32. Begistri	SQUARE SULTI	E 103 WALDON	RF, MD 2060	3						
Regist	ar	31. Date filed (Month, Day, Year) JUL 0 2 1997	Signature Skurdson Rand	all								



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	1 - FOR STATE REGISTRAR	STATE OF MARYLANI		TMENT OF H			IENE . NO.					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEA	тн	3. TIME OF DEATH				
	CLAUDE	WESLEY	ŀ	HALL		JUNE 29	, 1997	2:50 AM M				
	4. SOCIAL SECURITY NUMBER		s. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRT (Month, Day, Y	H (er)	B. BIRTHPLACE (State or Foreign Country)				
	220-10-8496	1 M 2 □ F 84	YRS.	MONTHS DAYS	HOURS MIN.	03/29/2	913	MARYLAND				
~	9a. FACILITY NAME (If not institution, give st	treet and number)		9b. CITY, TOWN O	OR LOCATION OF DE	EATH	9c. COUNT	Y OF DEATH				
DIRECTOR	PO BOX 158	ERSET										
EC	10s. STATE 10b. COUNTY	10d. INSIDE CITY										
DIR	MARYLAND SOMER		1 TYES 2 NO									
AL	10e. STREET AND NUMBER			ER FAIRM	. ZIP CODE		10g. CITIZI	EN OF WHAT COUNTRY?				
FUNERAL	PO BOX 158				21867	U.S.						
P.	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2	ARMED ONO	13. WAS DEC	ENDENT OF HISPAN	NC ORIGIN? (Speci	fy Yea or No-	4. RACE — American Indian, Black, White, atc.				
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES			2 NO Specify		,	Specify:				
	15. DECEDENT'S EDUC	CATION 164	. DECEDENT'S	USUAL OCCUPATIO	ON .	165 KIND C	F BUSINESS/INDU	WHITE				
ETE	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kind of w life. Do NOT us	rock done during mos	st of working	TOD. KIND C	P DOSINESS/INDO	SINI				
4	7		AVY EQ	UIPMENT	OPERATOR	COUN.	ΓΥ ROADS					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, N						
BE (	HARRY B. HALL				FLORE	NCE BYR	)					
2	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rural I							
-	HARRY FRANKILN HAL	<u>-L</u>	30185	CURTISS	ROAD, MI	ECHANICS	VILLE, N	ID. 20659				
	20s_METHOD OF DISPOSITION 1											
	4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LIC	BEE	:CHWOOD		Y ()	7/01/97	PRINCE	SS ANNE, MD.				
8		20/			IN FUNERA			21853				
_	Frank X	MEKNER MODE		11673	SOMERSE	T AVE	PRINCES	S ANNE. MD.				
	23. MRT/I. Entar tha diseases, Dr c ahock, or heart fallure. I	complications that causad the List only one cause on each	a death. Do n line.	ot enter the mod	da of dylng, such	h as cardiac or	raspiratory arre	st, Approximata				
	MMEDIATE CAUSE (Final disease or condition	maxa	- J		0	~	1-					
	disease or condition resulting in death)  a. Metastatic Prostate CA = 345  Due to (OR AS A CONSEQUENCE OF):											
_												
CERTIFICATION	Sequentially list conditions, If any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):											
S	Cause. Enter UNDERLYING CAUSE (Disease or Injury	с,										
	that initiated events	DUE TO (OR AS A COM	NSEQUENCE OF	):								
ER	reaulting in death) LAST	d										
AL C	PART II. Other aignificant condition	a contributing to death but n	ot resulting i	n tha underlying	cause given in	Part I. 24a, W	S AN AUTOPSY	24b, WERE AUTOPSY FINDINGS				
CA						PE	RFORMED?	AVAILABLE PRIOR TO COMPLETION DF CAUSE				
9						''''	ES 2 NO	DF DEATH?				
2	DID TOBACCO USE CONTR	RIBUTE TO CAUSE OF D	EATH YE	S   NO	UNCERTAIN	VA		1 120 2 100				
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		PLACE OF DEAT	H (Check only one)		/ -						
YSI	1 TES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpatien	nt 3 🗆 DOA	OTHER: 4 Nursing Home	Residence	8 Other (Specify	)					
H	27. MANNER OF DEATH  1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	JRY WOI		28d. DESCRIBE	OW INJURY OCCU	RED				
BY	2 Accident Investigation				ES 2 NO							
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — A building, atc. (Specify)	it home, farm, s	treet, fectory, office		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
<u>Li</u>	29a, CERTIFIER											
COMPLET	(Check only CERTIFYING PHYSIC	CIAN: To the best of my knowledge										
8		R: On the basis of examination and	yor Investigation	i, in my optivion, de	eath occured at the	time, data and pla	e, and due to the	cause(a) and menner as stated.				
BE	26. SIGNATURE AND TITLE OF CERTIFIER	11X	to	,4	29c. LICENSE NUM	BER /	29d. DATE	SIGNED (Month, Day, Year)				
2	30. NAME AND ADDRESS OF PERSON WHO	O COMPI ETED GAUGE OF DEATH	(ITEM 27) (To	Driet	7790	X7//	16	130/97				
	SAMMA	N/OX	(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	Print) Po	2000	L	0 1	20				
	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S SIGNATUR	SEI R	111	CON	701	< //					
	( 1 ) . WHERE	32. REGISTRAR'S SIGNATUR	entron-way	794								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Deeth **Physician** Month NHOL HINDMAN 10 26 PM 1997 JUN /Medical 4a. Facility Nema (If not institution, give street end nymber) 4b. City, Town or Location of Deeth 4c. County of Deeth **Examiner** OF MARYLAND SALTIMOZE If Undar 24 Hrs. 7. Age (In yrs. lest birthday) Sacurity Numbar Birthplace (Stete or Foreign Country) **Funeral** Months Deys 1 ★ M 2 F Hours 212-16-8830 Director 2 Maryland Dec Usuel Rasidence of Decedant the Marylan 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Rising Sun MD Ceci1 1 XYas 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21911 USA 117 Cooper St. Funeral 12. Wes Decedant Ever In U,S Armed Forces? Race - Amaricen Indian, Bleck, White, etc. 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) traumetic event, the Medical Examiner filed within 72 hours after 1 ဩYas 2 ☐ No If Yes, Give Year or Dates: Ţ 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 6 White ģ 1 ☐ Yes 2 XNo Specify: Specify 3 Widowed 4 □ Divorced "natural". WWII Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Spacify only highast grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Postal Clerk U S Post Office 18. Mother's Name (First, Middla, Maiden Sumeme) Pages 1 and 2 should be fit ment of Health and Mental He ant: If hem 27 is marked oth lury or other traumetic event 17. Fether's Neme (First, Middle, Last) Margaret G. Reeder John C. Hindman, Sr. 19a. informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Dorothy H. Brokaw, Sister 119 Reynolds Ave Rising Sun MD 21911 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cramatory or other plece) 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Ramoval from State Department of Important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) Brookview Cemetery June 28 1997 Rising Sun MD 21. Signature of Funeral Service Licensee 22. Name end Addrass of Facility T. Foard Funeral Home 111 S Queen St. Rising Sun MD 21911 Enter the disaasa, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiretory errest, or heert feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediata Cause (Final diseese or condition resulting In death) Examiner Examiner or Attanding Physician: The lew requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in death) Lest Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? signed by 1 Yes 2 No 3 Probably 4 Unknown þ page 2 should be Completed 24b. Were eutopsy findings availeble prior to completion of cause of deeth? 24e. Wes an autopsy performad? 2 No this certificate 1 Yes 1 ☐ Yes 2 ☐ No director. Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 🗷 Inpatient 2 ER/Outpetlent 3 DOA funeral 28e. Dete of Injury (Month, Dey Yeer) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Affer 5 Pending investigation 1 Naturel s efter death. 1 Tyes 2 No 2 Accident filled in by the 6 Could not be determined 3 Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locetion (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital
within 24 hours e
To the Funeral C 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier Medical 29b. Signatule and title of on 29c. License number 29d. Data signed (Month, Day, Year) WN 26 30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

S-12-D BALTMORE, MD

Registrar **DHMH 16 Rev 6/95** 

State

Yours

JUN 30 1997

ERIC

31. Dete filed (Month, Day, Year)

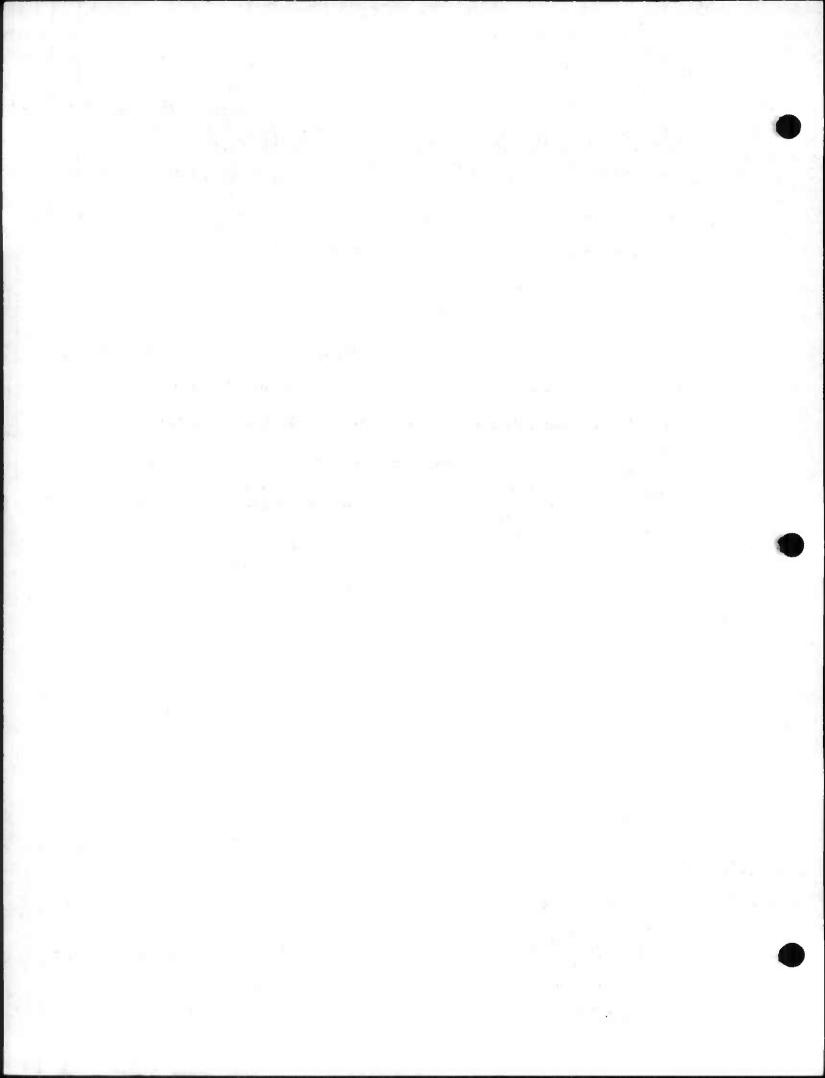
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32. Registrar's Signature

"in Davidson

GREENE ST

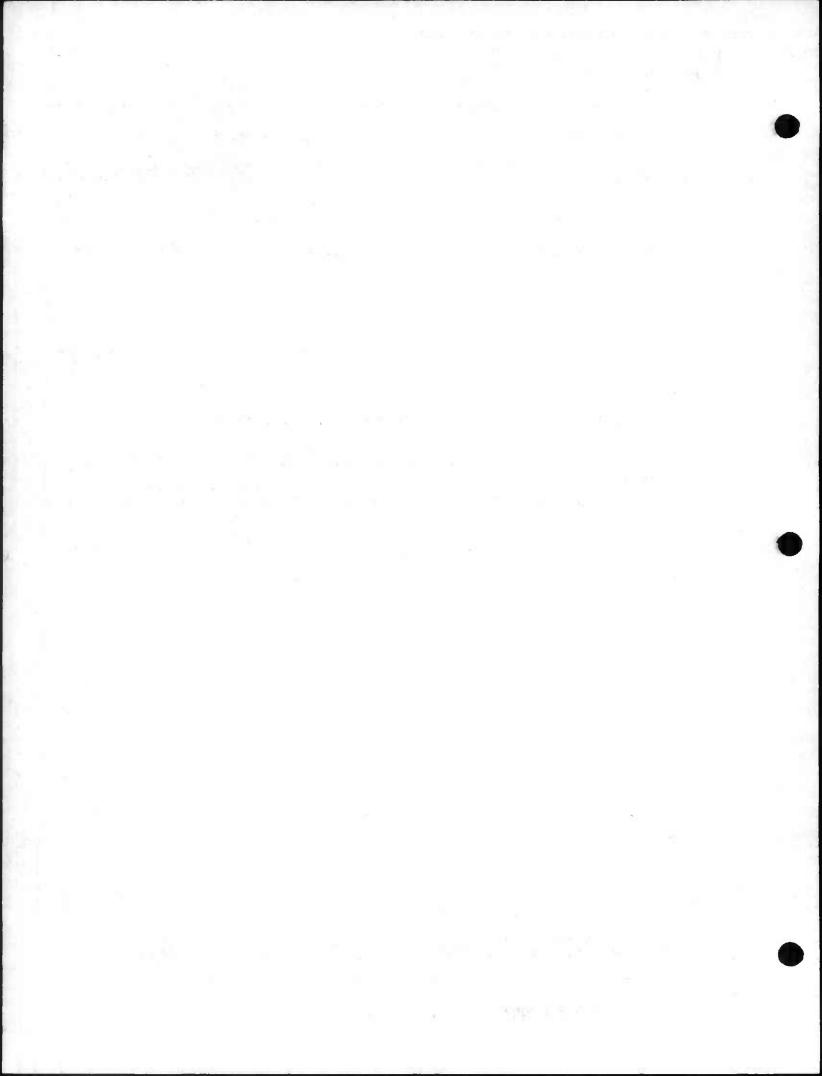
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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 2 1 0 3 9

Certificate of Death Item:8 per FH G-750 8/14/97 dh 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month Dey 24 Thomas Hodgson June 1997 03:00 /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** Calvert Memorial Hospital Prince Frederick Calvert 5. Sociel Security Number If Under 1 Year 8. Date of Birth 1965 9. February 3 1986 If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign
 Country) **Funeral** Deys ★□ M 2□ F 32 Yrs. Director 024 60 3445 Usuel Residance of Decedent Massachuettes permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Meryland Depertment of Health end Mentel Hygiene. Important: If tan 27 is marked other than "natural". or Harmon any injury or other trainment. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 693 Running Fox Road 1 ☐ Yes 2 ☑ No Directo Calvert Lusby 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 693 Running Fox Road 20657 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white Completed by 3 Widowed 4 Divorced Year or Date 86-95 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Sacondery (0-12) College (1-4or 5+) computer anylist US Government 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Herbert Hodgson Clarice I Scott 2 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Rhonda Hodgson- wife 693 Running Fox Rd. Lusby Maryland 20657 20b. Place of Disposition (Neme of cemetery, crematory or other place)
Metroplitan Funeral Service 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Alexandria Virginia 22. Name end Address of Fecility Rausch Funeral Home of Faherill Service Licensee 4405 Broomes Island Rd. Port Republic Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errast, shock, or haart failure. List only one cause on each line. Approximete Intarvel Batween Onset end Death **Physician** Immediate Causa (Final disease or condition rasulting in deeth) ASCUL /Medical **Examiner** Due to (or as e consequence of): Examiner The law requires that the death certificate be executed the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceusa (Disaase or injury that initieted events resulting in death) Lest Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): signed by the et ld be deteched fo Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 ☐ Probably 《☑ Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Was en eutopsy performed? certificate 1 Yas 2 No 1 Yes 2 No or Attending Physician: Be 25. Wes case referred to medical examinar? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No this i Director: After the 27. Menner of Deeth 28e. Dete of Injury (Month, Day Yeer) Medical Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Naturel 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) within 24 hours efter To the Funarai Direc completely filled In by 4 Homloida Hospitai 1 Certifying Physicien: To the bast of my knowledga, daath occurred et tha tima, data and piece, and due to the causa(s) and mannar as stetad.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daeth occurred et the tima, data and place, and due to the ceuse(s) and mennar statad. 29a. Certifier 29b. Signature end title of certifier 29c. Licanse number 29d. Data signed (Month, Dey, Year) 30. Nama end addrass of person who completed causa of death (Itam 23a) (Type, Print) Prince Frederick, MD. David Tardio 20678 31. Date filed (Month, Day, Yaar) 32. Registrar's Signature State Jalin Stovideor Randall Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible,
State of Maryland / Department of Health and Mental Hygiene 2 1 0 4 0
,6/23/97, drw Certificate of Death Reg. No.

Amend 10b, Calvert, 6/23/97, drw 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8: 45 pm Kichard June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Arundel Hospita Anne Arunde If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12XM 2□ F Yrs. 579 38 3688 Director 66 1930 Wash.. Usual Residence of Decedent death with the Maryland 10b. County Calvert 10a. State 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at MD Anne Arundel North Beach 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4100 Chestnut Ave. 20714 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1952-54 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mentel Hygiene. Important: If Item 27 is marked other then "neturelf, or ite eny injury or other traumatic event, its Modical Exeminal 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 ₹ Divorced Completed 15. Decadent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) sheet metal worker construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be William Hunt Mary Baldwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Andrew L. Hunt/son 4100 8th Street, North Beach, MD 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 6-23-97 Clinton, MD 21. Signature of Funeral Service Liestifs 22. Name and Address of Facility Rausch Funeral Home, Owings, MD Paint. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Bety Onset and Death Physician /Medical Immediate Cause (Final ACPIRATION PHIEUMONIA disease or condition resulting in death) Examiner Examiner CHRONIC BRONCHITIS burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting In death) Last and ARTERIOSCIEROTIC CARDIOVASCULAR DISFACE Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical Due to (or as a consequence of) 88 signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 □ Probably 4 □ Unknown ğ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

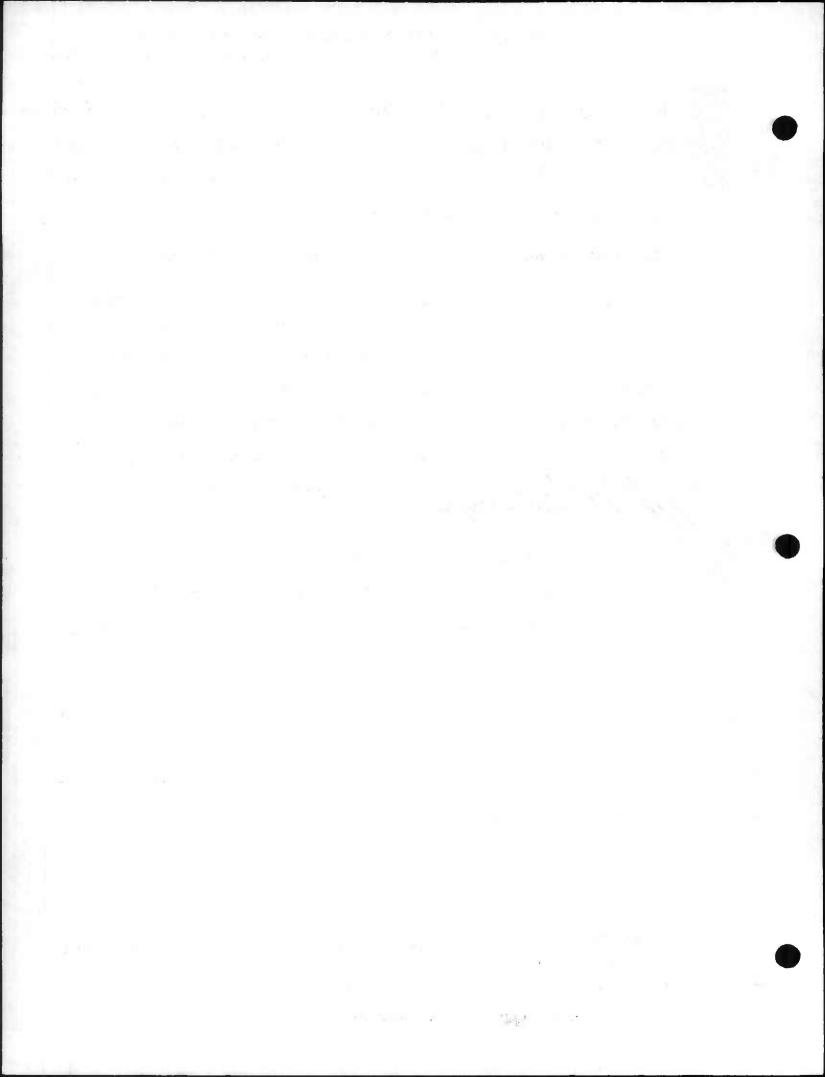
To the Funerel Director: After this certifice Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28c. Injury at Work? 27. Manner of Deeth Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 2 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 1997 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE. GUEN RURNIE MS 301 - HOSPITAL - 3 ONABAHO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Jalia Davidson Rarlall

Registrar

JUN



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 2 1 0 4 1

				Certificate of	Death	Re	eg. No.		
П	Division		Decedent's Neme (First, Middle, Last)		- :	2. Dete of Deetl	h		Time of Death
	Physici /Medi		Annie Catherine Hebb			Month June 1	, 1997	9er 2	:30 AM
	Examir		4e. Fecility Neme (If not institution, give street end number)		4b. City, Town, or Loca	ation of Deeth	4c. County of I	Deeth	
			Bayside Nursing Center		Lexington	Park	St.	Mary	's
	Funeral Director		5. Sociel Security Number 6. Sex 7. Age (In yrs. last b	birthdey) If Under 1 Yeer Months Deys	Hours Min	B. Date of Birth (Month, Dey, December	Year) 9. 27, 1932	Birthplace ( Country) Maryla	Stete or Foreign and
	end w		Usuel Residence of Decedent  10e. Stete 10b. County 10c. City, To	wn or Location				10d. In:	side City Llmits
	Manyl f she	0		mpton					☐ Yes 2 ■ No
	the 1288	Director	10e. Street end Number	10f. Zip Code		10	0g. Citizen of Whe	t Country?	
	3a o		22355 New Town Neck Road	20627			nited St		
020	be filed within 72 hours after death with the Maryland nat hygiene. Adother than "naturef", or items 23a or 28a-f show event, the Medical Examiner must be excilled at	by Funeral	11. Maritel Stetus  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorcad  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Yes 2 ■ No If Yes, Give Yeer or Dates;	13. Wes Decedent of I If Yes, specify Cub	Hispanic Origin? (Spec en, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)		American Inc White, etc.	
0	2 hou	be	15. Decedent's Education 16	e. Decedent's Usuel Occu	petion		16b. Kind of Busin		
21215-0020	should be filed within 7: nd Mental Hygiene. marked other than "numatic event, the Medi	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done life. DO NOT use retire Homemaker	during most of working d)	7	N/A		
b	Hygid Other	Be C	17. Fether's Neme (First, Middle, Last)		18. Mother's Neme	First, Middle, N	•		
an	should be nd Mental marked o	To B	William McLain Dorsey		Lucy Bo	lt			
Maryland		-	19e. Informent's Name/Relationship (Type, Print) 19	9b. Meiling Address (Street	t and Number or Rural	Route Number,	City or Town, Ste	te, Zip Code	)
	Health a		Mary G. Hebb-Price Daughter 2	21488 Exquis	ite Court,	Lexing	ton Park	, MD 2	0653
ore	of He of He litem		20a. Method of Disposition 20b. Placa	of Disposition (Neme of tery, cremetory or other pla			20c. Location - City		
<u>E</u>	Peges ment of 8 ant: If its ury or o		1■ Burial 2 □ Cremetion 3 □ Removel from Stete 4 □ Donetion 5 □ Other (Specify)	United Metho	dist 6/	6/97 L	exington	Park	, MD
Baltimore,	permit. Peges 1 and 2 Department of Health 1 Important: If itsm 27 it any injury or other tre		21. Signeture of Funerel Service Licansee  ard Brinsfield JR. MOO	22. Name end Addre	ess of Facility Ld Funeral 279, Leon	Home,	P.A. 206	50	
	_		23e. Pert1. Enter the disease, or completetions that caused the deeth. Do shock, or heart feilure. List only one ceuse on each line.						oximete
	Physician /Medical Examiner	95	Immediate Cause (Finel disease or condition resulting in deeth) e. Cardiu	ac Awas e consequence of):	Ty.	·^		Mu	vel Between et end Deeth
x 68760,	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	/Medical Examiner	if eny, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury c	e consequence of):	ychmi			M	'umlr
P.O. Box	es that the deeth cer igned by the attendir be detached for use	Physician/M							
o	y the	iysi	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause gi	ven in Part I.	23b. Did tol	bacco use contril		ause of death?
	that the detail			2		1 🗆 Ye	2 2 No 3	Probably	4 Unknown
Records,	w requires s been sign s should be	Completed by	Cancer of Bra	en .		24e. Wes er perform		eveilable	on of cause
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ta		Bec	25. Wes case referred to medical		26. Place of Deeth				
<b>&gt;</b>	ysicl Is cel direc	ToE	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/C	Outpatient 3 DOA Ott	her: 4 Jursing Home			Specify)	
0	neral			. Time of 28c. Inju	ry et 28		w injury occurred		
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Division of Vital	al or Atte s after de i Directo	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of Injury - At home, to building, etc. (Specify)	ferm, street, factory, office	28	f. Location (Str City or Town	n (Street and Number or Rural Route Number, Town, State)		
	To the Hospital or Attending Physician: The law within 24 buturs after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	edical (	29e. Certifier (Check only one)  1 Certifying Phyelcian: To the best of my knowledge and menner aleted.	je, deeth occurred et the ti and/or investigation, in my o	me, dete end pleca, en opinion, death occurred	d due to the ce l et the time, da	use(s) end menne ite end placa, end	er es steted. due to the c	ause(s)
	Toth Toth comp	Me	29b. Signature end title of cartifier  30. Name end edd/ess of person who completed cause of deeth (Item 23e)	29c. Licens	06419	29	6 -2	fonth, Dey, Y	'ear)
	Sta	te	James P. Jarboe, M.D.  31. Dete filed (Montl), Dey, Year)		ltown, Mary	land 20	0650		

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Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) Date of Death
 Month 3. Time of Deeth Harvir 06 TP 4e. Fecility Neme (If not Institution, give street end number), 4b. City, Town, or Location of Deeth 4c. County of Deeth HUNDER 1 Year If Under 24 Hrs. Montdoner arc Health lanner 5. Sociel Security Number 9. Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 578 522719 1□M 2 F Yrs. Usual Residence of Decedent 10e. State 10c. City, Town or Location 10b. County 10d. Inside City Limits D. C. WASHINGTON 1 Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5703 EAST CAPITOL ST., S. E. 20019 u. S. A. 12. Wes Decedent Ever In U,S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Maritel Stetus 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: BLACK Specify: 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 7TH GRADE HOMEMAKER Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) HENRY JAMES MYRA MILES 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) BENNIE HARVIN - HUSBAND 5703 EAST CAPITOL ST., S. E. D. .C 20019 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) CANE SAVANNAH CEMETERY 6/28 WEDGEFIELD, SC 21. Signature of Funeral Service Licenses 22. Neme end Address of Fecility PINCKNEY-SPANGLER FUNERAL HOME 23e Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one ceuse on each line. 20002 Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting In deeth) Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Last Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy 1 Tes 2 1 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 27. Menger of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) and menner stated. 29e. Certifier

Examiner Box 68760. Records, P.O. Division of Vital

burial-transit The law requires that the death cartificate be axecuted tha attanding f signed by the a certificata Aftar this To the Hospital or Attanding Pt within 24 hours after daath.
To the Funeral Director: After it complately filled in by the funera

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner inset to notified at

tha Maryland

daath with

Baltimore, Maryland 21215-0020

permit. Pagas I and 2 should be filed within Department of Health and Mental Hygiana. Important: If Itam 27 is marked other than any Injury or other trainment.

Physician

/Medical

Examiner

Physician/Medical

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Completed

Be

Medical Certification: To

29b. Signature end title of certifier

31. Dete filed (Month, Dey, Year)

JUN 24 199

State Registrar

29c. License number

29d. Dete signed (Month, Dev. Year)

30. Neme end eddress of person

(Item 23e) (Type, Print)

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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day 1997 Month JUN 17 JAMES WILLIAM HUBER 5:06 PM 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | Jan. 26,1940 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) XIX M 2 P Yrs. 57 10b. County 10c. City. Town or Location 10d. Inside City Limits XXYes 2 No Prince George's Upper Marlboro 10f. Zip Code 10g. Citizen of Whet Country? 14416 Colonel Fernwick Court 20772 United States 12. Was Decedent Evar In U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Bleck, White, etc. 1 ☑ Yas 2 ☐ No If Yes, Give Year or Dates: 57-77 1 Never Married 25 Married 1 Yes ≱ No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Security U.S. Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence F. Huber Mary Lucille Olive Wilson 19e. Informent's Neme/Raletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana L. Huber Wife 14416 Colonel Fernwick Court Upper Marlboro Md. 20b. Piece of Disposition (Name of cometery, crematory or other piece) June 23, Date 997 20c. Location - City or Town, Stete 20772 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stata Maryland Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham Maryland 21. Signature of Funeral Service Licenses 22. Name end Addrass of Facility Robert E. Evans Funeral Home, Inc. Enter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each lina. Approximete Intarvel Between Onset end Deeth PNEUMONIA days Due to (or as e consequence of): METASTATIC LUNG CANCER months Due to (or es e consequence of): Due to (or es e consequança of): Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Yes 2 No

Baltimore, Maryland 21215-0020 permit. Peges 1 end 2 should be file Deportment of Health end Mantal Hy Important: if Item 27 Is marked other any Influry or other traumatic event sonce. **Physician** /Medical Examiner The law requires that the deeth certificeta be axecuted Division of Vital Records, P.O. Box 68760.

attending physician end for use as the bunal-transit been signed by the s should be deteched s certificate has t director, pege 2 s director. funerai filled in by

**Physician** 

/Medical

5. Social Security Number

050 32 3337

Maryland

10e. Street and Number

10a. Stete

Usual Residence of Decedent

12

20e. Method of Disposition

Immediate Cause (Final disease or condition resulting in deeth)

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest

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Examiner

**Funeral** 

Director

ral', or items 23a or 28a-f show Examiner must be notified at

Direct

Funeral

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Completed the Medical

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Examiner

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should be filed within 72 hours after ond Mantai Hyglena. marked other than "natural", or iter

Physician/Medical ò Completed Hospital or Attending Physician: 24 hours efter death.

Funeral Director: After this certifica Be 2 Certification: To the Hospital
within 24 hours a
To the Funeral C

edical State Registrar

25. Wes case referred to medical examiner?

1 Yes 2 No 27. Manner of Deeth

1 Neturel

2 Accident 3 Suicide

4 Homicide

29a. Certifier

5 Pending invastigation

6 Could not be

Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

1X Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end menner stated. 29c. Licansa number

Q 1 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

D-51503

29d. Data signed (Month, Day, Year)

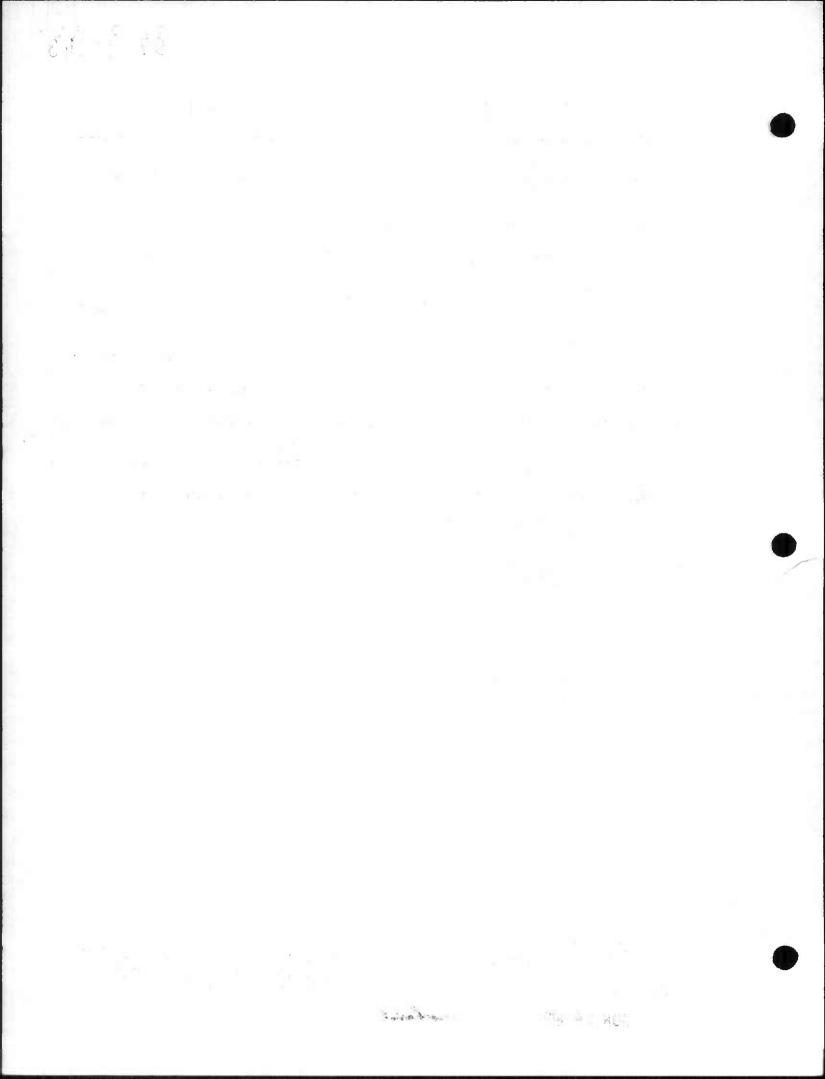
DAVID BLAZES, LT, MC, USN

NATIONAL NAVAL MEDICAL BETHESDA MD 20889-5600

31. Date filed (Month, Day, Year) JUN 24 1997

29b. Signatura and title of certifiag

32 Registrar's Signeture

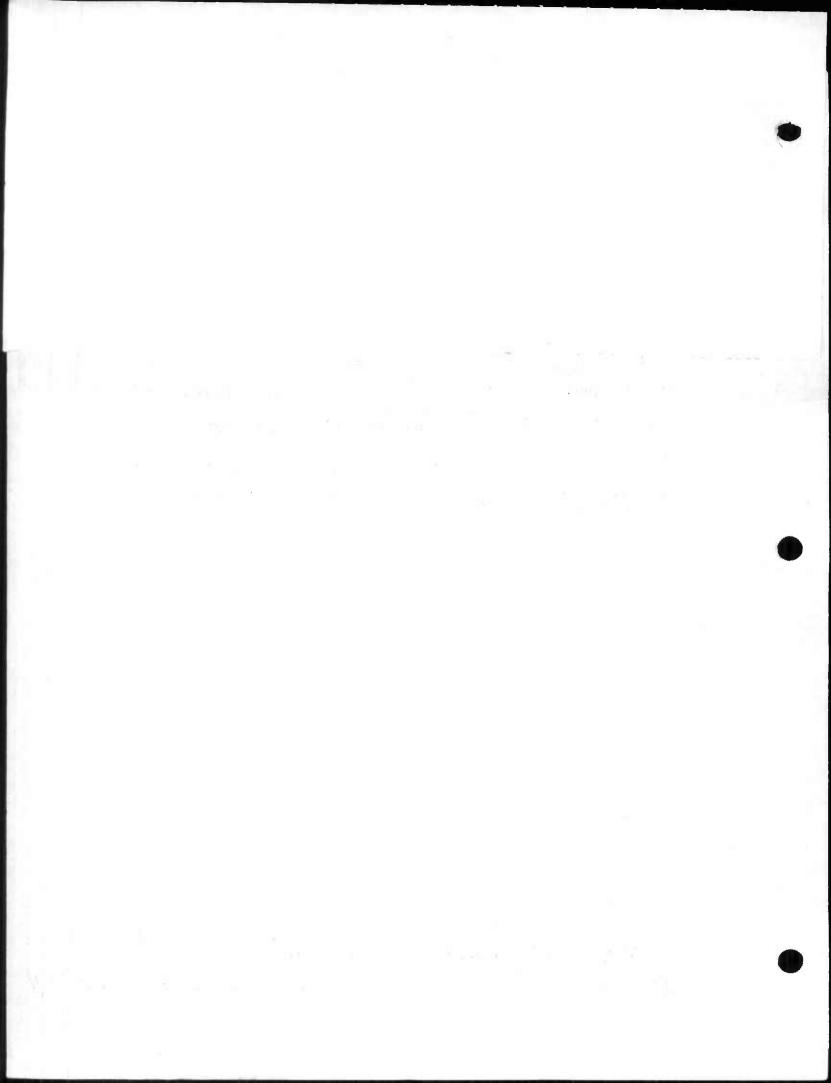


# Please Type or Print in Black Indelible Ink. Assure All Copies Are jegible 1044

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Physician /Medical Examiner City, Town, or Location of 4c. County of Death 7. Age (In yrs., last birthday) 36 Yrs. If Undar 1 Yaar If Under 24 Hrs. Data of Birth (Month, Day, **Funeral** Director Usual Rasidanca ot Decedant death with the Manyland 10e. Stete 10b. County 10c. City. Town or Location Show 10d. Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Haelith and Mental Hyglens. Important: if term 27 is marked other than "natural; or items 23a or 28a-f show any injury or other treumatic event, to Medical Examiner must be notified as Pa. Washington 1 ☐ ¥as 2 ☐ No Director Venetia 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 123 Bower Hill Road 15367 US 11. Manital Status 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Giva Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - American Indian Bleck, Whita, atc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedant's Education (Specify only highest grade complated) 16a. Decedant's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT usa retired) Elamantary/Secondary (0-12) Collega (1-4or 5+) Florist Floral 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Be Richard Huber Dorothy Ptaszkiewicz 19a. tntormant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Crystal Huber (wife) 123 Bower Hill Rd., Venetia, Pa. 15367 20b. Plece of Disposition (Nema of cemetery, crametory or other place) 20a. Mathod ot Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stete Beinhauer Crematory. 4 □ Dopation 5 □ Other (Specify) 6-28-97 Bridgeville, Pa. of Funeral Servica Licensaa 22. Nama and Address of Fecility
The Burbage Funeral Home 108 William St., Berlin, Md. ease, or complications that causad tha deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrast, in. List only ona causa on each lina. **Physician** /Medical Immediata Causa (Final diseese or condition rasulting In daath) Examiner Examiner g physician and as the burial-transit Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated evants rasulting in death) Last P.O. Box 68760, that the death certificate be Physician/Medical Dua to (or as a consequence of): been signed by tha attar should be datached for a Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings availabla prior to completion of cause of daath? 24a. Wes an autopsy performed? Completed 1 ☐ Yes 2 No cartificata 1 ☐ Yas 2 ☐ No Division of Vital To the Hospital or Attending Physician: Within 24 hours aftar death.

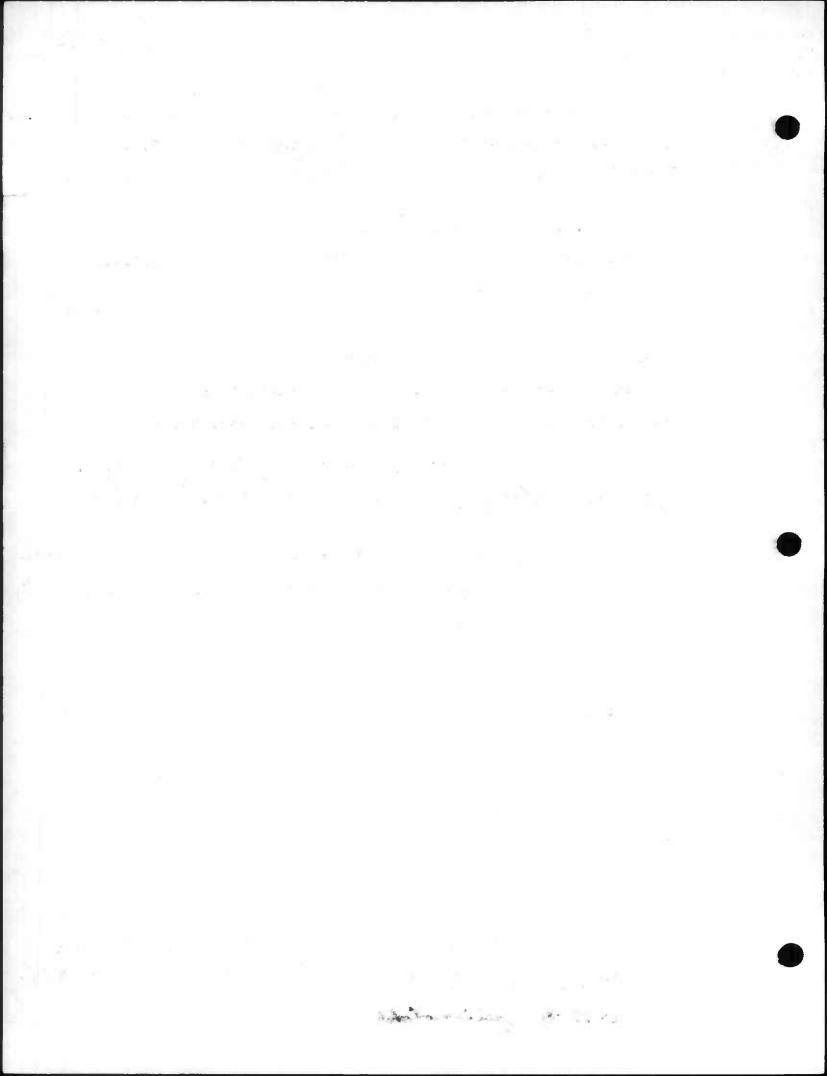
To the Funerel Director: Aftar this cartifica 25. Was casa rafarred to medical Be 26. Placa of Death (Check only ona) Othar: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA funaral 27 Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Natural 5 Panding 1 ☐ Yes 2 ☐ No invastigation 2 Accident 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, tarm, streat, tactory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) fillad in by 4 Homlcida Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian Medical 29d. Date signed (Month, Day, Year) 29b. Signeture end titla of certifie 30. Name and addrass RO 31. Dete filed (Month, Day, 32. Registrer's Signatura State Registrar



## Please Type or Print in Black Indelible Ink. Assure All Copies Areo epible 1045 State of Maryland / Department of Health and Mental Hygiene

				Oldic of IV	iai yiai ia /	Certificate o			Reg. No.			
	Physic	ian	Decedant's Name (First, Middle					2. Date of De Month	ath Day	Yaar	3. Time of Death	
	/Medi Examir		William A  4a. Facility Name (If not institution)	rcher Har	rison	Jr.	4b. City, Town, or I	Location of Death		97	9:48A.M	
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	Funeral Director				ga (In yrs. last bi	rthday) If Under 1 Ya. Yrs. Months Day	ar If Under 24 Hrs.	8. Data of Birt (Month, Da	h y, Year)	9. Birthpla	ace (State or Foraign ry) inia	
	p ,		Usuat Residence of Decedent  10a, State 10b, County						3,2352			
	death with the Meryland ms 23s or 28s-f show	2	10a. State 10b. County		10c. City, Tow	n or Location			10d			
	vith the Meryle or 28s-f shor	Funeral Director	MD P.G	•	Ft.	Washingto			1 X Yas			
	th with 23s or	ā	6801 Bock Rd						-		.yr	
	death w	Jera	11. Marital Status	12. Was Deceden		2074	f Hispanic Orlgin? (S	pecify Yes or No		S.A.	in Indian,	
21215-0020	or its	by Fur	1 ☐ Naver Married 2 ★ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed Forces  1  Yes 2  If Yes, Give  Year or Datas	No	If Yes, specify C	uban, Maxican, Puert	o Rican, etc.)	Specify			
2-0	72 hours 'natural', dical Exa	D D	15. Decadant	s Education	16a	. Decedent's Usual Occ	cupation	altia	16b. Kind of Bi		Lack ustry	
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	77 50 6		12			Cab Drive			Priv			
Maryland	ould be fi Mental H arked ott	Be	17. Father's Name (First, Middle, L					ne (First, Middle,	Maiden Surnam	(e)		
Z	should by the Menta	2	William Arc 19a. Informant's Name/Relationsh			Maiting Address (Stre		a Geer	or City or Town	State Zin	Codel	
Ma			Hazel Harris			301 Bock					2006)	
Baltimore,	permit. Pages 1 end 2 Depertment of Health a Important: If item 27 li any Injury or other tre once.		20a. Mathod of Disposition	3 □Ramoval from State	20b. Place of cemeta	f Disposition (Name of ry, crematory or other p	nlace)	Date	20c. Location -	City or Tow		
Ħ	nit. Pertme		4 □ Donation 5 □ Other (Sp 21, Signature of Funeral Service L		Harmo	ony Cemet	ery	6/25/9	7Lando	ver,N	1d.	
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	Physician /Medical		Immediate Cause (Final	6-5-6		Cura	1.0			i	Onset and Death	
	Examiner		disease or condition resulting in daath)	a. SEF		SHOC	K.				2-days.	
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0	e exe lan er uriel-t	EX	Saquentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disaasa or Injury that initiated events	CH	FF.					i		
68760,	ificete be execul g physician end es the buriel-trer	edical	that initiated events resulting in death) Last	c.	Due to (or as a	consequence of):						
	E 000			d.								
Box	attendin for use	ian		u								
P.O.	thet the death cer ed by the attendir deteched for use	Physician/M	Part II. Other algnificent condition	s contributing to death	but not resulting i	n tha underlying ceuse	given in Part I.	23b. Did 1	obecco uaa co	ntribute to	tha cause of death?	
	ss that the gned by be detect	by Ph	STROKE	7				10	Yes 2□ No	3 □ Prob	ably 4 Unknown	
Records,	law requires thet the death cert les been signed by the attendin 2 2 should be deteched for use	Completed						24a. Was perio	an autopsy mad?	avai	re autopsy findings ilable prior to apletion of cause aath?	
æ	The la	E O						101	as 2 No		Yes 2□ No	
ta		Be C	25. Was case referred to medical				26. Place of Dea	ath (Check only o				
of Vital	SOD	To	examinar? 1 ☐ Yes 2 No	Hospital:	iant 2 ER/O	utpatient 3 DOA	Othar: 4 Nursing H	ome 5 Resid	dence 6 □Oth	er (Specify,	)	
n	ding PI h. After ti funera	in o	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Inj (Month, D		Time of 28c. In Nigry	jury at /ork?	28d. Describe h	now injury occurr	ed	F-16	
Sio	tendi deeth tor: A	cati	2 Accident investigation inve	ot be			☐ Yes 2 ☐ No	***				
Division	I or Attendi efter deeth. Director: A d in by the fu	Certification:	4 ☐ Homicide determin	ned 286. Place of Ir	ijury - At homa, fa tc. <i>(Specify)</i>	ırm, street, factory, offic	ee .	City or Tox	Street and Numb vn, State)	er or Rural	Houte Number,	
	Hospital or Attending the hours efter deeth. Funeral Director: After field in by the fune		29a. Cartifier 174 Certifying	Phyaician: To the best	of my knowledge	death occurred at the	time date and place	and due to the	cause(s) and me	nnar ac ets	ated.	
	To the Nospital or Attending Phwithin 24 hours efter deeth. To the Funeral Director: After thi	edicai		xaminar: On the basis of and manner s	of examination an	d/or Investigation, in my	opinion, death occu	rred at the time,	date and place,	and due to	the cause(s)	
	Within 24 To the Fu	X	29b. Signature and title of certifiar	8 mag	1	29c. Lice	nse number		29d. Data signe	d (Month, D	ay, Year)	
	1		•	0000	W	D.	-3452	2	06-	20-	-97.	
	()		30. Nama and address of parson w	no completed causa of	death (Itemp3a)	liste a	ad; to	220; 6	Bourie	-M	0-20716.	
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 23	1997 32. Regist	rar's Signature	Cold		,				



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State of Maryland / Department of Health and Mental Hygiene 2 1 0 4 6

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** HARPER 7:15 PM JUNR 30 199 /Medical 4e. Fecllity Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner A PLATA JARES NURSING HOME
7. Age (In yrs. last birthday) If Und COUNTY if Under 1 5. Social Security Number 6 Sex Year If Under 24 Hrs. Year) May Birthplece (State or Foreign Country) **Funeral** 84 Yrs. Months 1 □ M 2 1 F Days 227-09-156 1913Washington Director Usuai Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Director 1 ☐ Yes 2 XXXo Maryland Prince George's Upper Marlboro 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 12404 Apple Court 20772 United States deeth Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes, 2 ☐ XXX If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Status Peges 1 and 2 should be filed within 72 hours after on the hear of Heelin and Mental Hygiena.
Int: If fem 27 is marked other than "natural", or itea into or other traumatic event, the Medical Evantina iny or other traumatic event, the Medical Evantine. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ TYO Specify: Completed by 3€Widowed 4 □ Divorced Specify.White 15. Decedent's Education 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th Office Worker The Carpenters Union 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Leonard Church Callie Phillips 19a. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita Noone Apple Court, Upper Marlboro, Md 20772 20b. Plece of Disposition (Name of July 3, 1964) cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Depertment of Important: If any injury or Cedar Hill Cemetery Suitland, Maryland 21 Signature of Funeral 5 22. Name end Address of Facility Lee Funeral Home, Inc 663301d Alexandria Ferry Rd, Clinton, Md 20735 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete intervel Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examiner The lew requires thet the death certificete be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical the Due to (or es e consequence of) use as ete has been signed by the etter page 2 should be detached for Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? rkinson's Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy Dementi certificete 1 Yes No No 1 ☐ Yes 2 ☐ No or Attending Physician: funerel director. 25. Was cese referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Aftar this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Naturei 2 Accident To the Hospital or Attending within 24 hours efter death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) end menner steted. Medica 29b. Signature and title of cartifie 29c. License number 20d Dete signed (Month, Day, Year) , M.M. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) ERKINS 1317 LaPlata Ave, LaPlata Md 32. Registrer's Signature State Registrar

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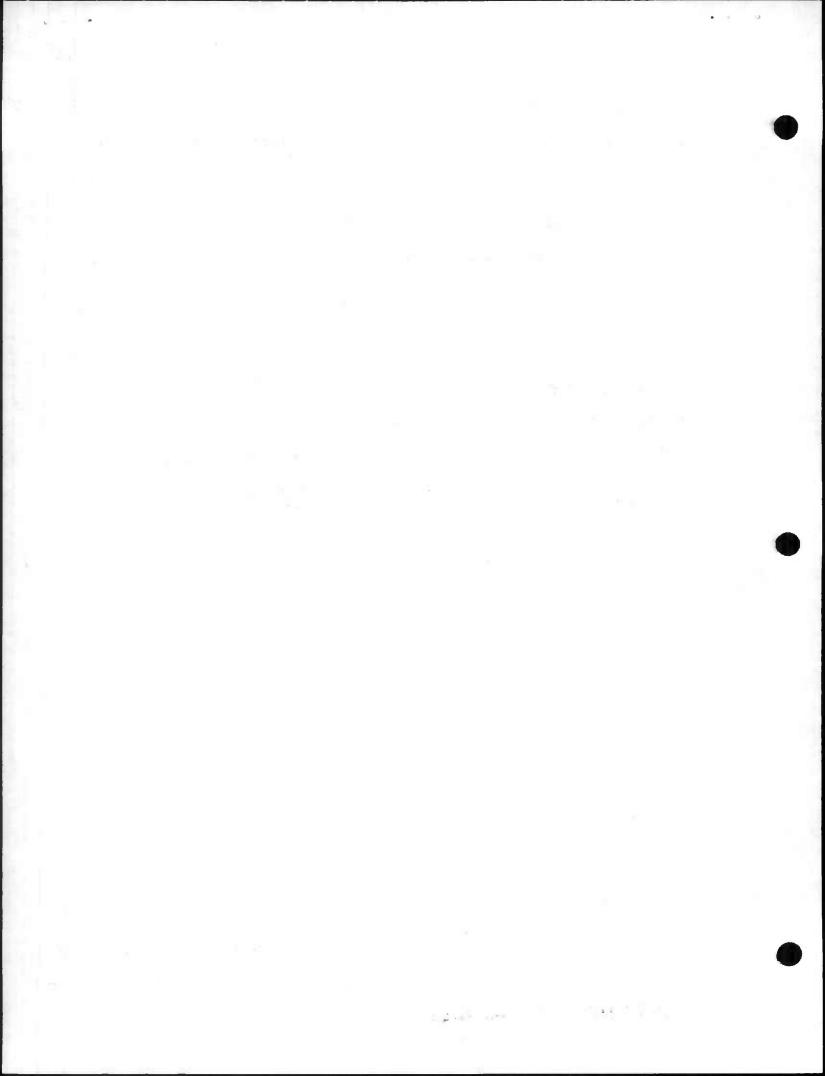
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Physic	ian	Decedant's Neme (First, Middle, Last,	)		Cei	tificate	or or	Death	2. Data of De Month	Reg. No. ath Dey	Year 3.	Time of Death
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Baltimore, permit. Peges 1 an Department of Heal important: if item 2 any injury or other once.		21. Signature of Funeral Sarvice Licans	1000	1	22	. Nama and	Addra	ass of Facility				
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	6	30. Neme and address of person who co Robert T. Chas 31. Data filed (Month, Day, Yaar)	8/ 7		100	ennt) E. Ca	rro	oll St.	Salish	nery h	(·D.	

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State of Maryland / Department of Health and Mental Hygiene 7 2 1 0 4 8

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	Exami		4e. Fecility Name (If not institution, give	street end number	)			4b. City, Town, or L		4c. County				
			Fairland Adven	tist Nur	sing C	enter		Silver	Sprin	g Mon	tgom	ery		
	Funeral Director		5. Sociel Security Number 6. S 129-24-4734  Usuel Residence of Decedent	ex 7. A □M 2[x] F	ge (In yrs. lest bir 96	Yrs. If Und Months	er 1 Year Deys		8. Date of Birth (Month, Dey 12/1/	Year)	9. Birthple Country Georg	ce (Stete or Foreign y) gia		
	P &		10a. State 10b. County		10c. City, Tow	n or Location					100	d. Inside City Limits		
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	death with the Maryland ms 23s or 28s-f show r.mst be notified at	erai Dir	10e. Street end Number			014	209	V .			.S.A	• 1		
020	illed within 72 hours after death with the Marylar hygiene. The than "natural", or items 23s or 28s-f show ither than "natural", or items 23s or 28s-f show ith the Medical Examiner must be notified at	by Funeral	11. Maritel Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces  1 Yes 2 In If Yes, Give Year or Detes:	ecify Yes or No- Rican, etc.)		e - Americer ck, White, et Bla							
5-0	72 hc	ted	15. Decedent's Ed (Specify only highest gra	ucetion	16a.	Decedent's Us	uei Occu	pation	ring	16b. Kind of Bu	usiness/îndu	stry		
Maryland 21215-0020	d within glene. or than "	Completed	Elementary/Secondary (0-12)	College (1-4or		omesti		during most of worked)		Privat	e Ind	dustry		
pu		Be	17. Fether's Neme (First, Middle, Last)					18. Mother's Nem	e (First, Middle, I	Maiden Sumeme)				
ylai		To	Joseph Dayı	Joseph Daymon Fannie M. DeVaughn										
	d 2 ah th and 7 is m freum		19e. Informent's Neme/Relationship (7) Reliford T. By:			_		tend Number or Rui 13 above		r, City or Town,	Stete, Zip C	ode)		
Baltimore,	or offh		20e. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □		cemete	Disposition (Nay, cremetory or	other pla	6/28/		20c. Location -		n, Stete		
葦			4 ☐ Donation 5 ☐ Other (Specify  21. Signeture of Funeral Service Licen	<u>*</u>	OICH			ess of Fecility	71	wasii.,	D.C.			
Ba	permit. Departr Imports any inje		Xary &	/ /	w	Н.	S.W	ashingto urroughs	n & So Ave.,	ns,inc				
68760,	eath certificate be executed a strending physician and ifor use as the bunal-transit	al Examiner	Due to (or es e consequence of):    Due to (or es e consequence of):									~ 2 day		
Box 687	h certificata ending phys use as the	n/Medical	thet inititeted events resulting In deeth) Lest  Due to (or es e consequence of):											
	0 0 0	sicis	Part II. Other eignificant conditions co	intributing to death t	out not resulting in	the underlying	cause o	ven in Pert I.	23b. Did to	bacco uee co	ntribute to t	he cause of death?		
% P.O	requires that the de leen signed by the a hould be detached to	by Physician/								es 2 No		bly 4 Unknown		
Vital Records,	Paw Is b	Completed t							24e. Wes e perform		eveil	e eutopsy findings able prior to pletion of cause seth?		
<u> </u>									1 □ Y	es 2 No	10	Yes 2□ No		
<u>Vit</u>	iclan: The certificata ractor, pag	Be	25. Wes cese referred to medical examiner?	Manadani				26. Plece of Deel	th (Check only or	ne)				
	this aldi	<u>1</u>	1 ☐ Yes 2 € No  27. Manner of Deeth	Hospital: 1 ☐ Inpati			NA		ome 5 Reside					
Division of	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completaly filled in by the funer	Certification:	1 Neturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28e. Dete of Inju (Month, Da	ay Year) li	ime of njury M		ry et irk? ] Yes 2 □ No		Describe how injury occurred				
Div	ital or Al ars after or rai Directied in by	1	Suicide  4 Homicide  See Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)  See Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)  See Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)  See Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)											
	To the Hospital of within 24 hours a To the Funeral D completely filled	Medical	29a. Certifier 1  Certifying Phy (Check only one) 2  Medical Exam	rsician: To the best iner: On the basis of and manner st	of examinetion en	, death occurred d/or investigatio	d et the t n, In my	me, date end place, opinion, death occur	end due to the cared et the time, d	ause(s) and me ate end plece,	enner es stet end due to ti	ed. ne ceuse(s)		
	With To 1	2	29b. Signeture end title of certifier	W		29	9c. Licen	- 1787	74	9d. Date signer	23	iy, Year) -97		
			30. Name end address of person who o	ompleted cause of	deeth (Item 23a) (	Type, Print)	Ast=	- 1787 COTTAG	LE CITY	MD	20	722		
	Sta	te	31. Date filed (Month, Day, Year)		rer's Signeture	-0 /	. 40			3 -				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legiple. 2 | 049 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** George Ellison Ireland 9 dune d /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Union Hospital of Cecil County E1kton Cecil if Under 1 Year 5. Sociel Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys 1**X**) M 2□ F 74 Yrs. 217-18-1596 Director 1922 Maryland Usual Residence of Decedent tha Maryland 10e. State 10b. County 10c. City. Town or Location 7 is markad other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar mant be notified at 10d. Inside City Limits 1 ¥Yes 2 ☐ No Director Mary land Ceci1 Chesapeake City 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 309 Bohemia Avenue 21915 U,S,A, daath Funeral 12. Was Decedent Ever in U,S. Armed Forces?
1 ⅓ Yes 2 □ No If Yes, Give Yeer or Detes: ₩₩ II Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status filed within 72 hours aftar. Mygiana. Ither than "natural", or Ite 1 Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 11 Mechanic Automotive markad other permit. Pagas 1 and 2 should be file Department of Haalth and Mantal Hy Important: If Itam 27 Is marked other any Injury or other traumatic event ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) George Washington Ireland Helen Ellison 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Naomi Ireland - Wife P.O. Box 416 - Chesapeake City, MD 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 6-26 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Bethel Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 1997 Chesapeake City, MD 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P;A; 103 W; Stockton Street - Elkton, MD 21921-5521 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical War-Small Call Lay Cause Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner Attending Physician: The law requires that the death cartificate be executed physician and s the burial-tran Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): cata has been signed by the page 2 should be detached Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ≥ Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were eutopsy findings evailable prior to 24e. Wes en eutopsy completion of ceuse of deeth? 1 Yes 2 No this cartificata 1 Yes 285No 25. Was case referred to medical Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ SR/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Dey) funaral 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Aftar 1.25 Neturel 2 ☐ Accident 5 Pending daath. 1 Yes 2 1√10 investigation haral Director: A 6 Could not be 3 Suicide Place of Injury building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) At home, ferm, street, factory, office Hospital or At 24 hours after of 4 Homicide To the Mospital within 24 hours a To the Funaral C complataly filled Descertifying Phyeicien: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) end menner es steted.

| Wedical Examiner: On the best of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier Medical 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dev. Yeer) C100002768 30. Name and address of person who complete duse of deeth (Item 23e) (Type, Print) Martha A. Hosford-Skapof, M.D. - 111 W. High Street - Elkton, MD 21921 32. Registrar's Signature State

Registrar

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 1 0 5 0 State of Maryland / Department of Health and Mental Hygiene

					State of W	aiyiaii		tificate			vieritai myt	eg. No.			
		Ŋ,	1. Decedent's Neme (Fit	rst, Middle, Last)							2. Dete of Dea	th		3. Time of Deeth	
	Physici		Kenneth La	awrence	Irwin, S	r.					Month May 30	, 1997	Year	6:00 PM	
	/Medic Examir		4a. Fecility Neme (If not	institution, giva s	treet and number)				4b	. City, Town, or L	ocation of Death	4c. County	of Death		
			18955 McKa	ays Cove	Lane				I	Leonardt	own	St	. Mar	y's	
	Funeral Director		5. Social Security Number 143-18-112	1 1	M 2□ F	ge (In yrs. 72	last birthdey) Yrs.	If Undar 1 Y Months D	aar	if Undar 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey June 6,	1924	9. Birthple Count New	ace (State or Foreign  y)  Jersey	
	/land		Usuel Residence of Dec. 10a. State 10b	edent . County		10c. City	, Town or Loc	cation			10d. inside City Limits				
	with the Maryland a or 28a-f show be notified at	to	Maryland	St. Mar	v's		Leona	rdtown	1					1 ☐ Yes 2 ■ No	
	r 284	Director	10e. Street end Number		<del>y</del>			10f. Zlp Co	de		1	0g. Citizen of V	Vhet Count	ry?	
	th wit	ai D	18955 McKa	ays Cove	Lane			206	50			Unite	d Sta	tes	
020	efter dee or items	by Funeral	11. Marital Status  1 Never Married  3 Widowed 4	2 Married	2. Was Decedent Armed Forcas? 1 Yes 2 If Yes, Give Yaar or Detas:	? If Yes, specify			edent of Hispanic Origin? (Specify Yas or Necify Cuban, Maxicen, Puarto Rican, atc.)  2 No Specify:				e - Amarica k, White, e		
Maryland 21215-0020	within 72 hours ene. then "neturel", he Medical Exe	Completed	(Specify or Elementery/Secondary	Decedent's Education of the Control	etion		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Inc								
7	filed within Hygiene.	S	12	Baidala Land			Civ	vil Ser			- /87			rnment	
anc	2 2 2 2	Be	17. Fathar's Name (First, Edwin L.	11.00							na <i>(First, Middla, :</i> th Hamme		a)		
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Ma	d 2 sl th en 7 is r traur	ı	19e. informent's Neme/F								ral Routa Number				
	of Health end Mer of Health end Mer f frem 27 is marks or other traumatic		Lorraine I		ı WII	20b. P	lece of Dispos	sition (Nema o	of		e, Leona	20c. Location -			
JO I	ages ant of t: If it y or c		1 ☐ Buriei 2 ☐ Cra 4 ☐ Donetion 5 ☐		amovel from Stata		- 0	natory or othai							
Baltimore,	permit. Pages Department of Important: if it any injury or c	1	21. Signature Pulsal		011	7 Met		Ltan Cr .Name end A			6/2/97	Alexano	ria,	Virginia	
ä	permit. Departr Importr sny inj		Edward	Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650											
	Physician /Medical Examiner	immediata Cause (Final disease or condition Final disease or condition									i	Approximate intervel Between Onset end Death			
		iner	resulting in death)	- h		Due to (o	as e consequence	uence of):	1+1	en Di	Stare.	,	~	2 725	
90,	icate be executed physician end s the burial-trensit	il Examiner	Sequantially list condition if any, leading to immedicause. Enter Underlying Cause (Diseese or injury	ens, iete		Due to (or	r es a consedi	uance of):							
x 68760,		Medicai	thet initieted events rasulting in daeth) Last			Due to (or	es e consequ								
Вох	death certifi e attending ed for use es	lan											Î		
	0 0 0	Physician/M	Pert II. Other significant	conditions con	ributing to death b	out not resu	ılting in the un	derlying ceus	e give	n In Pert i.	23b. Did to	obacco uee co	ntribute to	the cause of death?	
s, P.O	res that the de signed by the a be detached t	by Ph									1 U Y	20 No	3 Prob	ably 4 Unknown	
of Vital Records,	aw requi	Completed									24a. Was a perfor	in autopsy med?	con	re autopsy findings llable prior to apletion of ceuse eath?	
H		2									1□ Y	es 2□No	10	Yes 2□ No	
Vita	yalclan: The is certificate director, per	Be	25. Wes casa referred to examiner?						0.1		ith (Check only or	10)			
of	<u>0</u> 0	5	1 Yes 2 No	n			ER/Outpatien		Other	4   Nursing H	ome 5 Resid			)	
n C		ion		Pending Investigation	28e. Dete of inju (Month, De	lry ly Year)	28b. Time of injury	28c.	Work'	et ? es 2 □ No	28d. Describe h	ow injury occur	ed		
Division	To the Hospital or Attending within 24 hours after deeth.  To the Funeral Director: After completely filled in by the fune	Certification:	2 ☐ Accident 3 ☐ Suicide 6 [ 4 ☐ Homicide	Could not be detarmined	28e. Piece of in building, et	jury - At ho c. (Specify	me, farm, stre	eet, factory, of		65 2 1110	28f. Location (S City or Town	traet end Numb n, State)	er or Rural	Routa Number,	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edicai C	29a. Cartifiar (Check only one)	Certifying Phya Medicai Examin	cian: To the best er: On the basis o end menner st	f examinet	wledga, daath ion and/or Inv	occurred at tr astigetion, in	na tima my opi	a, date and piece nion, deeth occu	, and dua to the c rred et the time, d	eusa(s) end ma ate and piace,	innar as sta end due to	ated. the cause(s)	
	withir To th	Me	29b. Signatura and titla o	of certifier				29c. Li	canse	number	2	9d. Date signe	d (Month, E	Day, Year)	
			1/4	orus.	- M.	0		10	3	6206		05131	167		
	13	ŀ	30. Neme end eddress o	f person who cor	npleted cause of c	death (Item	23e) (Type, I			0 0		-//	9/		
			12	PAN		16.									
	Sta Registr		31. Deta filed (Month, Da	IIIN 03	1997 Nagist	ar's Signe	ture Ra	rdall							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nerge (First, Middle, Last) 2. Dete of Deeth Month es mm 4c County of Deeth 4b. City, Town, or Lecation of Death 4e. Fecility Name (If not institution) erve street and number RINCE Thern BN ANU IN Inne Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday Days 1□M 25FF 213-42-8468 Yrs. 56 November 18, 1940 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's 1 Ves 2 □ No Maryland Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 13304 Van Brady Road 20772 USA 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ②No If Yes, Give Year or Detes: 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced Specify: Black 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Cosmetologist Self-Employed 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) John Oliver Windsor Leora Brownon 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Alphonsus Johnson Husband 13304 Van Brady Road Upper Marlboro Maryland 20772 20e. Method of Disposition 20b. Piece of Disposition (Name of cemetery, crematory or other piece) Dete 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State June 23, Washington National Cemetery Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 1997 21. Signature of Funeral Service Licensee 22. Neme and Address of Facility Adams Funeral Home 20605 Aquasco Road Aquasco Maryland 23a. Part1. Enter the visease, or complications that clused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart filture. List only one ceuse on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Final diseese or condition resulting in deeth) Due to (of es e consequence of): Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting In death) Lest Due to (or as e consequence of): Due to (or as a consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 N ER/Outpetient 3 □ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. tnjury et Work? 28d. Describe how injury occurred

Division of Vital Records, P.O. Box 68760,

be executed buriel-trensit end signed by the ettending physician d be deteched for use as the burie should hes certificate Mospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certifica funeral in by the

Examiner Physician/Medical þ Completed P Certification: pletely filled edicai within 2

**Physician** 

/Medical

Director

Funeral

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Be

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar invest be notified at

permit. Peges 1 and 2 should be filed within 72 hours effer to Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Macildal Examination.

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

death with the Meryland

1 Naturel

2 Accident

3 Suicide

29a. Certifier

4 - Homicide

(Check only one)

29b. Signature end title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

1 ☐ Yes 2 ☐ No

Branch Ave ChinTon

2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

CYRUS V. PARSET 8700 MD. 0/0

5 Pending investigation

6 Could not be determined

32. Registrer's Signeture Jalia Davidson Randall

28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify)

**DHMH 16 Rev 6/95** 

State

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Voor REGINA DOROTHY JAMES 1997 1:35 AM. June 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth St. Mary's Hospital Leonardtown
If Under 24 Hrs. 8. Da
Hours Min. (M St. Mary If Under 1 Year 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) Deys 1 ☐ M 2 🖾 F Yrs August 14, 1933 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside Cltv Limits St. Mary Hollywood 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of Whet Country? 24485 Mt. Plesent Rd 20636 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, 2 Yes, Give X
Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ₺ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Post Master U.S. Postal Service 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Thomas Alvin Hayden Dorothy Frances Garner 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Patricia A. Hayden/Daughter 24465 Lefty Lane, Hollywood, MD 20636 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) St. John's Cemetery 6/20/97 Hollywood, MD 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Mattingley-Gardiner Funeral Home, P.A. raela 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, a heart feilure. List only one cause on each line. Approximate Intervel Betw Onset end Deeth Adeno carcinomia of Colon Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of death? 1 🗆 Yes 2 NO 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Appatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end manner steted.

29c. License number

LEONARDTOWN, MD. 20650

29d. Dete signed (Month, Dey, Year)

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryle Dependent of Health and Mentle Hyglene. Important: If teem 27 is arrected other than "natural; or items 23a or 28s-1 show any injury or other traumatic event, its Nacional Examines must be inclined. Baltimore, Maryland 21215-0020

**Physician** /Medicai Examiner buriel-transit

**Physician** 

/Medical

5. Social Security Number

10a. State

MD

10e. Street end Number

20e. Method of Disposition

Immediate Ceuse (Finel diseese or condition resulting in death)

214-32-8924

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

by

Completed

Be 2

death with the Marylend

Physician/Medical Examiner The law requires that the deeth certificate be executed P.O. Box 68760, the 98 for use cete has been signed by the e pege 2 should be deteched þ Completed this certificate has director, Be ၉ filled in by the funeral Medical Certification: After s efter deeth

Division of Vital Records, or Attanding Physician: To the Hospital or within 24 hours eff To the Funeral Di completely filled in

REGINA JAMES

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) State Registrar

31. Date filed (Month, Dey, Year) JUN 18 1997

DAVID ALLEN M.D.

29b. Signature and title of pertid

1 ☐ Yes 2 No

27. Manner of Death

1 Neturel

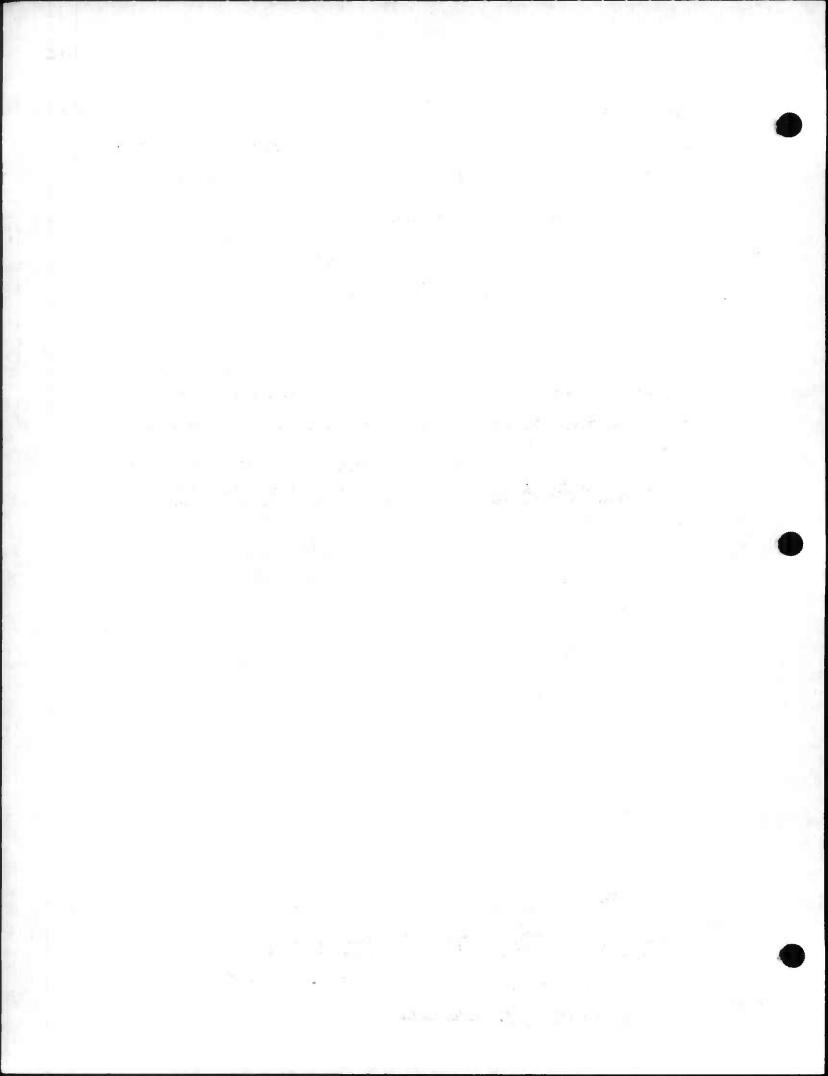
2 Accident 3 Suicide

4 Homicide

(Check only one)

29a. Certifier

32. Registrer's Signature Mk obwolen Rardall



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

			State of Ma	ryland		artment of l		Mental Hy	giene Rag. No.	1 2	1053	
		1. Decedent's Name (First, Middle, Lest	)					2. Dete of De			3. Time of Death	
Physi /Med		Anna Je	enifer					June 1	4 1997	Yeer	2:15 p.m	
Exam		4e. Fecility Neme (If not institution, give	street end number)				4b. City, Town, or		h 4c. Cour	nty of Deeth		
		Deaton University	of Maryla	nd Me	dicin	e	Baltimo	re				
Funera Directo		5. Social Security Number 6. Se 218-76-3947 Usual Residence of Decedent	7. Age	(In yrs. lasi	t birthday) Yrs.	If Undar 1 Year Months Days	if Undar 24 Hrs Hours Min	8. Dete of Bin (Month, De May 15	1916	9. Birth Cou Mar	pleca (State or Foraign ntry) yLand	
yland		10a. State 10b. County		10c. City, T	Town or Loc	cation					10d. Inside City Limits	
Mar a-fal	to	Maryland St. Mary	s	Lex	ingto	n Park					1 ☐ Yes ※ ☐ No	
ours after death with the Marylan sel', or Itams 23e or 28e-f ahow Examiner must be notified at	al Director	10e. Street end Number 127 Essex Drive				10f. Zip Code 20653	3			10g. Citizen of Whet Country? U.S.A.		
arms arms	Funeral	11. Marital Status	12. Was Decadent Ex Armed Forcas?	ver in U,S.	13. W	Vas Dacedent of I	Hispenic Orlgin? (S an, Mexican, Puer	Specify Yas or No	- 14. R	ece - Ameri		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-f ahow any injury or other traumatic evant, the Medical Estandar must be notified at once.	by	1 A Never Married 2 Marriad 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	)		☐ Yes 2 No		to riceri, atc.)	Spec	leck, White, cify:	Black	
	etec	15. Decedent's Edu (Specify only highest gred	cetion a completed)	1	6e. Deced	ent's Usuel Occu	pation during most of wo	rkina	16b. Kind of	Business/In	dustry	
	Completed	Elementery/Secondary (0-12)	College (1-4or 5+	)		o not use retire nemaker	during most of wo d)		Own	Home		
	To Be	17. Father's Name (First, Middle, Last) unknown					18. Mother's Na Unkno	ma (First, Middla )WN	, Maiden Sum	eme)		
		19e. Informent's Name/Reletionship (Ty Gene Carter/Guardia		,	P.O.	Box 653	end Number or Ri Leonard	urel Route Number, City or Town, State, Zip Code) Itown, MD 20650				
		20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	amoval from State	ceme	etery, crem	ition (Neme of eatory or other ple	,	Date 6/17/9	20c. Location 7 Lec		own, State	
permit. Departn Importa		21. Signature of Funeral Service License	Garden	2			ess of Fecility. 7-Gardine 270, Leor				20650	
		23a. Part1. Enter the diseese, or compli shock or heert failure. List only or	cetions thet ceused to	ne death. [	Do not ante	r the mode of dyi	ng, such es cerdia	c or respiretory e	rrest,		Approximete Intervel Between	
Physician /Medical Examiner		Immediate Ceuse (Final	Sopo	Sid .							Onset end Deeth	
381		resulting in death)	Aspin	ue to (or es	e consequ	ience of):	umo	Mã a			1 day	
eath certificate be executed attending physician end for use as the burial-trensit	Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury c.									2 425	
hysic the b	dical	thet initiated events resulting in death) Lest  Due to (or as a consequence of):									7	
v requires that the death certific been signed by the attending p should be detached for use as	Physiclan/Me	d Hyperteus a							3	everaly		
e dea the at hed fo	sic	Pert II. Other significant conditions con	tributing to death but	not resulting	g in the und	derlying ceusa giv	ren in Pert I.	23b. Dld	lobacco uee d	ontribute to	the cause of death?	
ss that th gned by be detac	by Phy							10	Yes 2□ No	3 Pro	bably 4@Unknown	
The law requires that the death certification is the has been signed by the attending page 2 should be detached for use as	Completed							24a. Wes perfo	en eutopsy med?	ev	ere eutopsy findings eilable prior to mpletion of ceuse deeth?	
The page	Con							10	res 2010	10	☐Yas 2☐No	
clan	Be	25. Was cese referred to medical examiner?						eth (Check only o				
physic this al dir	2	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	ospital: Inpatient		Outpatient	3□ DOA Otr	er: 4 Nursing H				y)	
Attending Physician: or death. actor: After this certific by the funeral director,	Certification:	1 ☑Naturel 5 ☐ Pending 2 ☐ Accident investigation	28a. Dete of Injury (Month, Dey )	/eer) 28t	b. Time of Injury	28c. Injur Wor M 1 □	y et k? Yes 2 □ No	28d. Describe I	now injury occi	urred		
tal or Atres effer of all Direct led in by		3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify)  28f. Location (Street and Number of Street)							nber or Rura	I Route Number,		
To the Hospital or Attending Physician: The law within 24 hours efter death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 ✓ Certifying Physical Check only one) 1 ✓ Certifying Physical Examination	clan: To the best of re: On the basis of exert end menner state	caminetion	ige, deeth o end/or inve	occurred at the tirestigetion, in my o	ne, dete and plece pini <i>on</i> , deeth occu	, end dua to the rred et the time,	ceuse(s) end ri date end plece	nanner es si e, end due to	teted. the ceuse(s)	
Vith To t	Σ	29b. Signature end titla of certifier	41			29c. Licens			29d. Data sign			
		· concenta.				2	1497	4.	6.1	6-9	),	
		30. Neme end address of person who cor	mpleted ceuse of dee	th (Item 23e	e) (Type, P	rint) + 121. (	3497 john	1670	Min	2-104	4	

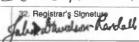
State Registrar

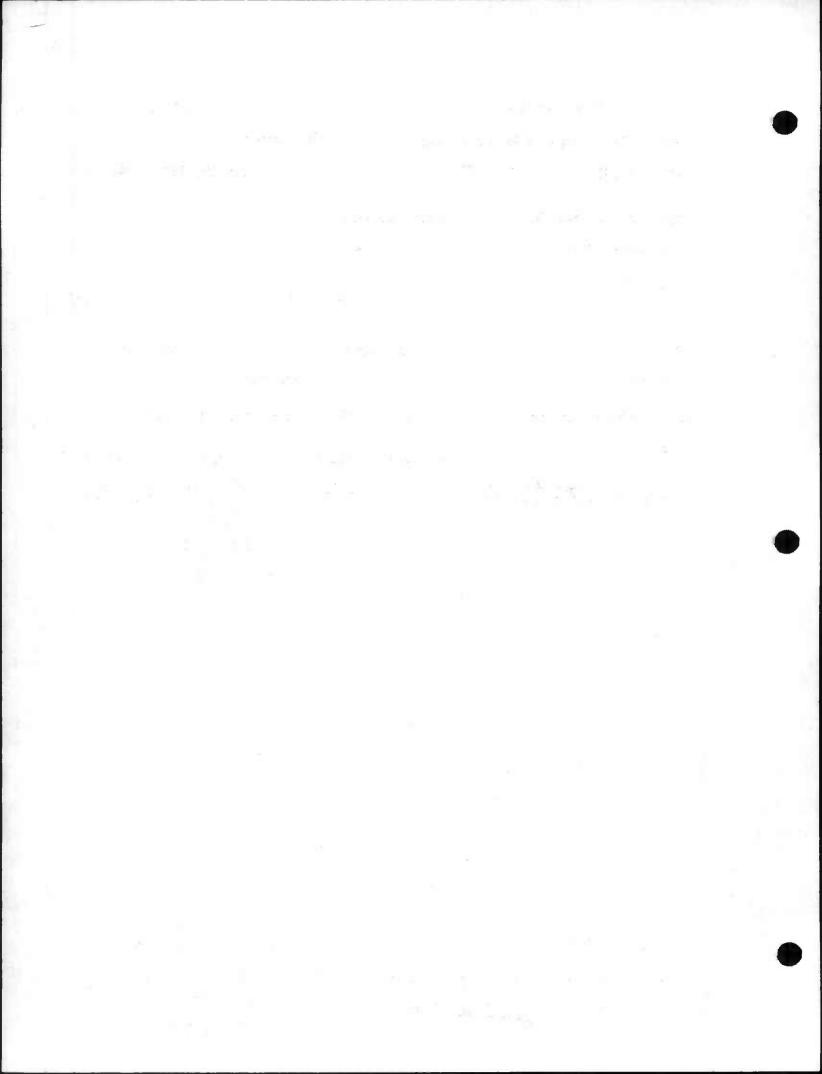
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

31. Dete filed (Month, Day, Year)

JUN 18 1997





#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) TYRE' MARCEL JONES

2. Dete of Deeth Month

3. Time of Deeth 23,1997 23:15 PM

10d. Inside City Limits

Approximate Interval Between Onset end Death

19 Yes 2 No

1 Yes 2 □ No

Examiner

**Physician** 

**Funeral** Director

ma 23a or 28a-f show permit. Pagas 1 and 2 should be filed within 72 hours aftar death with in Dapartmant of Haaith and Mantal Hygiana. Important: If Item 27 is merked other than "natural", or itema 23a or any injury or other traumatic event, the Madical Examines must be nown injury or other traumatic event, the Madical Examines must be nown.

Baltimore, Maryland 21215-0020 **Physician** /Medical Examiner

Attending Physician: The law requires that the death certificate be executed tha bunai-transit Division of Vital Records, P.O. Box 68760, usa as cartificata spital or Attending Physnous after death.
neral Director: Atter this y filled in by the funeral di this

JUNE /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth ROUTE 214 WEST AND ADVENTURE WORLD PRINCE GEORGES LARGO If Under 24 Hrs. 6. Sex 1**X**0 M 2□ F 7. Age (In yrs. last birthday) If Under 1 Year 5. Sociel Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Deys Hours 578-15-4051 NOV. 30, 1981 CHEVERLY, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director PRINCE GEORGES UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? # 25 LAUGHTON STREET Funeral 20744 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) STUDENT 10 **EDUCATIONAL** 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) THOMAS JONES SYLVIA EARL 19e. Informent's Name/Reletionship (Type, Print) MOTHER 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) MRS. SYLVIA EARL-MACKLIN # 25 LAUGHTON STREET UPPER MARLBORO, MD 20744 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) HARMONY MEMORIAL PARK 6/30/97 LANDOVER, MD 21. Signature of Funeral Service Licenses ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE FORESTVILLE, MD 20747 or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, heart failure. Unit only one cause on each line. Immediate Ceuse (Final disease or condition resulting in death) Multiple Injuries Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Physician/Medical Due to (or as e consequenca of) Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the ceuse of death? 1 | Yes 2 PNo 3 | Probably 4 | Unknown by Completed 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Was en eutopsy performed? 19 Yes 2 □ No Be 25. Was cese referred to medical exeminer? 26. Plece of Deeth (Check only one) exeminer: Yay Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE P 28e. Dete of Injury (Month, Day Year) 6-23-97 Certification: 27. Manner of Death 28b. Time of 28c. Injury et Work? 1 Natural Injury 1 Yes 2 No Pedosman Shrew by investigation 10 15 M 2 Acciden 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) A 2 4 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Roadina

To the Hospital o within 24 hours af To the Funeral Di completaly filled in

State Registrar

Medicai

1) awid 31. Date filed (Month, Day, Year) JUN 26 1997

29b. Signature end title of certifier

29a, Certifier

(Check only one)

111 Penn Street, Baltimore, Maryland 21201 32. Registrer's Signature Tolk Mudear Realett

30. Name end address of person who completed ceuse of death (Item 23e) (Type, Print)

29c. License number

OCME

**DHMH 16 Rev 6/95** 

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

JUNE 24, 1997

11. 20 12 1

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State of Maryland / Department of Health and Mental Hygiene 9 7 2 1 0 5 5

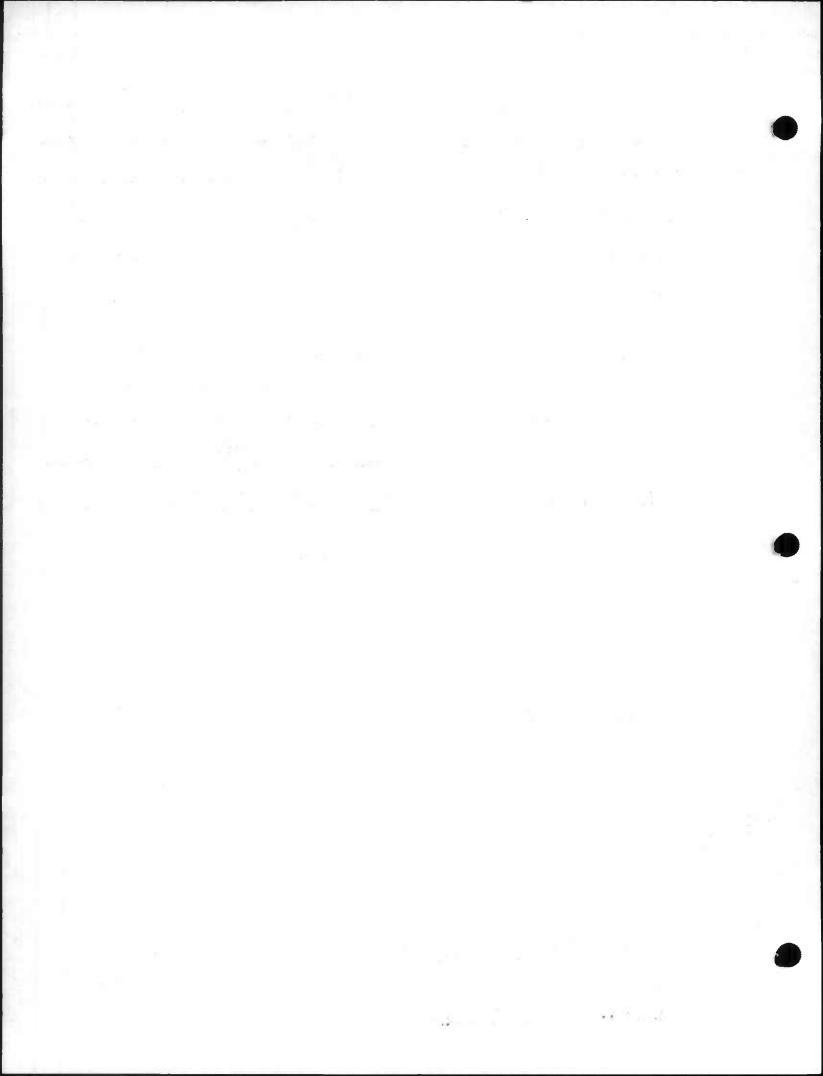
							Ce	rtificate	e or	Death		-	Reg. No.			
п	Dhunia	:	Decedent's Neme (F	irst, Middle, La	ist)							2. Date of De Month	ath Day	Year	3. Time of De	eath
	Physic /Medi		Doris	s E.	Joh	nson						June	23.	1997	8:11	P.M.
	Exami		4a. Fecility Name (If no	t institution, giv	e street end ni	um <i>ber)</i>				4b. City, To	wn, or Lo	ocation of Death	-			
	Exum	101	(000 0							Cl	1					
-			5. Social Security Numl			7 Age /in	yrs. lest birthday	If Under	1 Year		erly				eorge's	Constan
	Funeral				1□M 2⊠F		Yrs.	Months	Deys		Min.	8. Date of Birl (Month, De		9. Birting	olece (Stete or F	oreign
	Director		577-66-61 Usuel Residence of De			55	- 110.	<u> </u>				July 2	, 1941	Washi	ington, D.	.C.
	pue *			b. County		100	c. City, Town or Lo	ncation							10d. Inside City I	Limite
	sho	2													1½ Yes 2	
	Ba-f	cto		Prince	George'	S	Che	verly							IXI Tes 2	
	1 th	Jire	10e. Street end Numbe	r.				10f. Zip	Code				10g. Citizen of	Whet Cour	ntry?	
	h w	a [	6009 State	Stree	t				20	785			Unit	ed St	ates	
	dea	Funeral Director	11. Marital Status		12. Was Dec		in U,S. 13.	Was Deced	lent of I	Hispenic Ori	gin? (Spe	ecify Yes or No		ce - Americ		
0	of the		1 Never Married	2 Married	Armed F 1 ☐ Yes	21 No				oan, Mexicen		Hican, etc.)	Ble	ck, White,	etc.	
02	urs a	by	3 ☐ Widowed 4 ☐	Divorced	If Yes, G Yeer or I	ive Dates:		1∐ Yes 2	No	Specify:			Specia	y:	Black	
9	2 ho	Pe	15.	Decedent's E	ducation		16e. Dece	dent's Usue	l Occu	petion			16b. Kind of E	Business/In		
21215-0020	n 7	Completed	(Specify o	only highest gre	ede completed,		(Give	kind of wor DO NOT us	rk done	during mos	t of worki	ing				
12	with the	E	Elementery/Seconda	ry (0-12)	College	(1-4or 5+)		Hou					Dri	vate		
	Hygi Hygi nt,		6th 17. Father's Name (Firs	t Middle Last	)			Hou	SEW	1	r's Name	e (First, Middle,				
an	be do o	Be	_ `											110/		
Ž	Me Merke	10		Hollins	·			_				eth Rob				
Maryland	s 1 and 2 should be filed within 72 hours after death with the Menyland if Health end Mental Hygiene. Item 27 is marked other than "naturel", or items 23e or 28e-f show other traumatic event, the Medical Examinar mant be multiped at		19a. Informent's Name	/Relationship (	Type, Print)		19b. Maili	ng Address	(Stree	t end Numbe	er or Rura	al Route Numbe	er, City or Town	, State, Zip	Code)	
	es 1 and of Health I Item 27 r other tr		Sylvester	Hinnan	t Johns	son -H	usband 6	009 S	tat	e Stre	eet,	Chever	ly, Mar	yland	20785	
e e			20a. Method of Disposit				Ob. Place of Dispo cemetery, cre	osition (Nam	ne of	ace)		Date	20c. Location	- City or To	own, State	
Baltimore,	permit. Pages 1 and Depertment of Health Important: If Item 27 eny injury or other ti once.		Marial 2 □ C 4 □ Donetion 5 □					-			6	/28/97	Ruonti	boot	Marriar	n d
=	ortar		21. Signature of Funera				t. Linco			ess of Facilit		/20/91	preme	lood,	Marylar	.Iu
Ba	Depermine Depermine Important in Concession		11/1	TOL	L +	4		TEMART	FIII	MERAT	HOME	, Inc.				
)_			23a 1/rt1. Enter the d hock, or heart fe	1. 31	wan	711	_ 4	001 B	enn	ine Ro	ad	N E	Washino	ton	D. C.	
п			23a Jirt1. Enter the d	isease, or com ilure. List only	plications that one cause on	ceused the	death. Do not en	ter the mode	e of dyi	ing, such as	cardiac c	or respiretory er	rest,		Approximete Intervel Between	en
1	Physician		0			(1)									Onset end Dea	
	/Medical	ш	Immediate Ceuse (Final disease or condition	al	/	2000	J(-	10	1/	,					13 MON?	745
	Examiner		resulting in death)		θ	Duo	to (or es e conse	nuonoo of):								
		ē				Due	to (or es e conse	querice or).						1		
	certificate be executed iding physician and ise as the burial-transit	Examiner			b. ———		h- (	-								
_ E	al-tra	xa	Sequentially list conditi if eny, leading to imme- cause. Enter Underlyin Cause (Disease or Inju-	ons, diate		Due	to (or es a consec	quence of):						1		
68760,	certificate be executed iding physician and ise as the burial-transit		Cause (Disease or Inju	ng ry	c									i		
87	phys the	√Medical	thet initiated events resulting in deeth) Last			Due	to (or es a consec	juence of):						i		
ox 6	certifi nding   use as	Me		L	d									i		
Bo					J									1		
	he a	Sic	Part II. Other significan	t conditions o	ontributing to d	eath but no	resulting in the u	nderlying ce	euse gi	iven in Pert I.		23b. Did 1	obacco use co	ontribute to	o the cause of d	deeth?
P.0	that the decled by the a	Physicia										10	Yes 2 No	3 Pro	bably 4 ☐ Un	known
	es tha igned be del	by											6			
of Vital Records,	- W TO											24a. Was	en eutopsy		ere eutopsy find	lings
0	v requ been shoul	Completed										perfo	rmed?	co	eilable prior to impletion of caus	se
3e	e law has	d m											,	of	death?	
=	Page 1	S										101	res 2 No	1[	☐Yes Z☐No	)
'ita	Physician: The this certificate ral director, pa	Be	25. Was case referred exeminer?	to medical						26. Place	of Death	(Check only o	ле)			
2	ystc Is ce dire	2	1 Yes 2 No		Hospital:	Inpatient	2 ER/Outpatie	nt 3 DO	A Ott	her: 4□ Nu	rsing Ho	me 5 Resid	lence 6 □Oti	her (Specif	(v)	
			27. Menner of Death		28e. Dete	of Injury	28b. Time o	f 28	8c. Inju Wo			28d. Describe I			,,	
0	ding th.: After s fune	ti 0	1 Naturel 5	☐ Pending investigation		nth, Day Yea	nr) Injury	М		ork≀ ]Yes 2.⊟I	No					
Division	or Attending efter death. Director: After in by the fune	Certification:	3 ☐ Suicide 6	Could not b	e 28e. Place	e of Injury -	At home, farm, str	eet, factory.	. office			28f. Location /5	Street end Num	ber or Rura	al Route Number	r.
S	= 5 th 6	H	4 Homicide	determined	build	ing, etc. (Sp	pecify)	,,	,			City or Tou				,
	ospital or hours efte unerel Dir sly filled in		20a Cortifica	0.464	uetales Z ::											
	Hos 24 hc Fun tely	edical	(Uneck only /2	Medical Exen	niner: On the b	asis of exer	knowledge, deat nination end/or in	n occurred a vestigation,	in my o	me, date en opinion, deal	a place, e th occurre	end due to the o ed at the time, o	ceuse(s) end m date end place,	enner es si end due tr	teted. o the ceuse(s)	
	1889	Med	one)	/	and mar	mer stated.										
1	S TAN O		29b. Signature and pile	2 gertifier	(1111	1)	1,	29c.	. Licens	se number			29d. Date signe	d (Month,	Day, Year)	
1	1			Muy (	1661	-/	(h)		1)	203	52	_	6/2	4/9.	7	
Y	01	- 57	30. Name and address	of person who	completed cau	se of deeth	(Item 23e) (Type,	Print) _	-	,			-1	1 -	1	
1			HARNEL	, Wa	71011	MI	) 8	-920		4/2	1011-	- Varif	Del	'/	Man	1.
	Sta	to	31 Flore Bledy/Month	ear)	1 0.32/	Registra S		1-8		-00	10	- Light	1/.	-6/	10100	14
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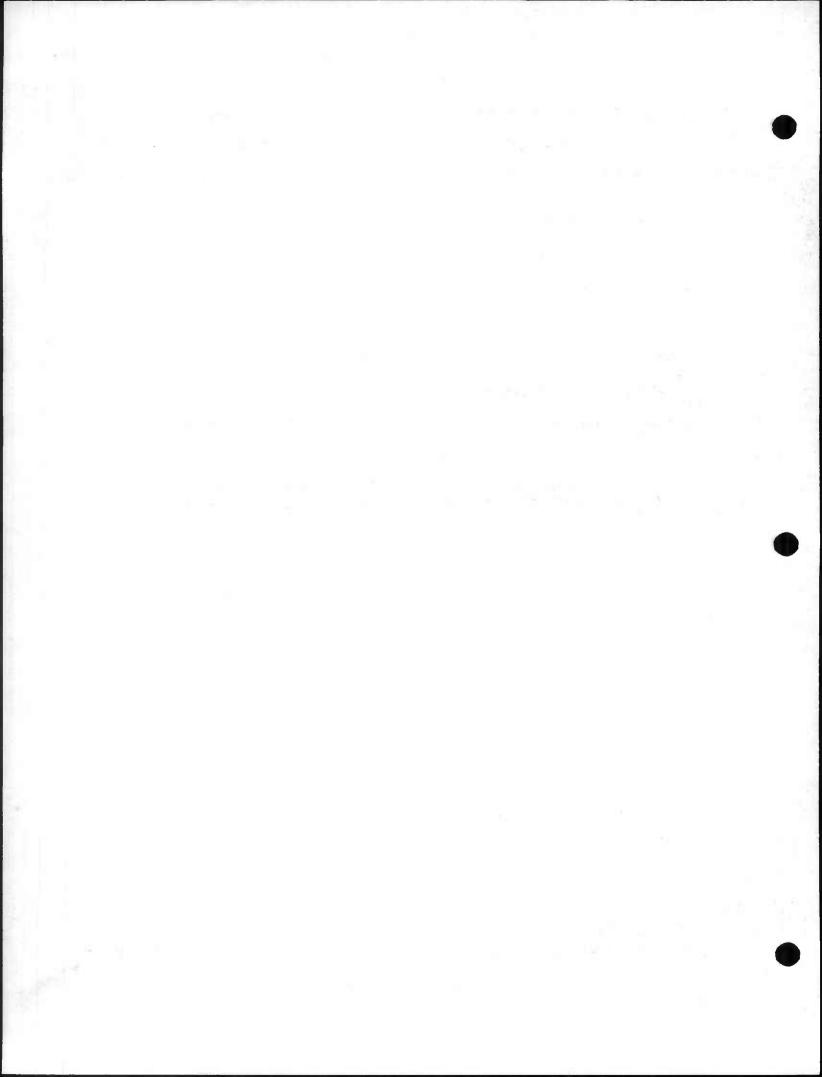
State of Maryland / Department of Health and Mental Hygien 2 | 056

					(	Certificate of	f Death		Reg. No.		
	Dhunia	·	1. Decedent's Neme (First, Middle, La					2. Dete of De Month		Year	3. Time of Death
	Physic /Medi		LEE A.	JOHNSON				JUNE		797	05:35pm
	Exami		4e. Fecility Neme (If not institution, give				4b. City, Town, or				Towns
			14600 OLD		POAD		BOWIE		PRINC		
	Funeral			Sex 7. Age 1. IX M 2 ☐ F	(In yrs. lest birtho	Months Dev			th y, Year)	9. Birthple Count	lece (State or Foreign try)
	Director		Usual Residence of Decedent		48 Yr			12-2	5-48	<b>Nashi</b>	ngton DC
	dand		10a. Stete 10b. County		10c. City, Town o	r Location				10	Od. Inside City Limits
	the Marylar 28a-f show	to	Maryland Prince	George's			Bowie				1 ¥ Yes 2 □ No
	28a	9	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Whet Count	try?
	within 72 hours after death with the Maryland ena. than "natural", or items 23a or 28s-f show the Marical Examinat Le notified at	Funeral Director	14600 01d Stage	Road			20715		l	USA	
	ltems 2	ner	11. Maritel Status	12. Was Decedent Ex	ver in U,S.	13. Was Decedent of If Yes, specify Cu	Hispenic Orlgin? (S	pecify Yes or No	- 14. Rac	e - America	
0	aftar or Ite	3	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give				to Hican, etc.)		ck, White, e	
00	ours ral',	1 by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 ☐ Yes 2000N	o Specify:		Specify	a DI	ack
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ā,	- P E E		20a. Method of Disposition	3 011 01	20b. Place of D	isposition (Neme of			20c. Location -		
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	parmit, Pag Department Important: I any Injury o		4 ☐ Donetion 5 ☐ Other (Special 21. Signeture of Funerel Service Lice)	**	Harmon	22. Name and Add		1997	Landove	ar , 140	aryranu
P	Dep imp any		h .1			1 D 100	king Fund	eral Hom	е		
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	polications that caused to	he death. Do not	7474 Lan	dover Roa	d, Land	over, Ma	ırylaı	nd 20785
1	Physician		shock, or heart failure. List only	one ceuse on each line	).		, ,	o or roop, orong	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Interval Between Onset end Death
	/Medical		Immediate Ceuse (Finel	a CHRONIC	REI	N- FAIL	LIRE			i	
	Examiner		disease or condition resulting in death)		Oue to (or es e cor						
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	certificate be executed nding physician and use as the burial-transit	Examiner	Sequentially list conditions,	b	oue to (or as e cor	sequence of):					
30,	se exe		Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury								
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o	that tha death ed by the atter datached for u	ysle	Pert II. Other elgnificant conditions of	contributing to death but	not resulting in th	e underlying ceuse g	given in Pert I.	23b. Did	tobacco uee cor		the cause of death?
۵.	es that tigned by		ETHANOL A	BUSE, CH	HRONIC.			1 🗆	Yes 2 No	30 Prob	ably 4 Unknown
of Vital Records,	S 50	d by		(				24a Wes	en eutopsy	24b. We	ere eutopsy findings
00	v require been si should	lete							med?	eve	pliable prior to mpletion of ceuse
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5	Physician: this certific ral director,	o B	organiner?	Hospital:	t 2 ER/Outpe	otient 3 DOA	26. Place of De: ther: 4 \( \text{Nursing } \)	ath (Check only o	one) dence 6 ⊡Oth	on (Consit	4
			27. Manner of Deeth	28a. Dete of Injury	28b. Tim	e of 28c. Inj			how injury occurr		,
ion	Attending In death.  Actor: Aftar by the fune	atio	1 A Naturel 5 ☐ Pending 2 ☐ Accident investigation	( <i>Month, D</i> ey	Y99 <i>r)</i> Inju		ork? ⊒Yes 2⊒No				
Division	or Attend after death Diractor: /	1110	3 ☐ Suicide 6 ☐ Could not be determined	289. Place of Injur		, street, factory, office	9	28f. Location (	Street end Numb	er or Rurel	Route Number,
	s after s afte	Certification:	4   Homolds	building, etc.	(Зреспу)			City or Tox	W11, 3(0(0)		
	he Hospital or Attent in 24 hours after deat he Funeral Diractor: pletely filled in by the	1	29a. Certifier Certifying Ph	yelcian: To the best of	my knowledge, d	eath occurred et the	time, date end place	and due to the	ceuse(s) end me	nner es ste	eted.
	he H in 24 he Fi plete	edical	one)	niner: On the basis of e end manner stete	ed.	r investigetion, in my	opinion, death occu	irred et the time,	date end place, a	and due to	the cause(s)
	200	Σ	29b. Signature and title of certifier	100 Z	h	29c. Licer	nse number		29d. Date signed	d (Month, E	Day, Year)
V	/L)		gunn	your !	IN D	NE 03	3754		JUNE	25,	1997
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15	_		MARIO F. GO.		\$ ,30	of HOSPIT	7954 70 PRIVE	CHEV	EKLY 10	MAY	MAN, 1018
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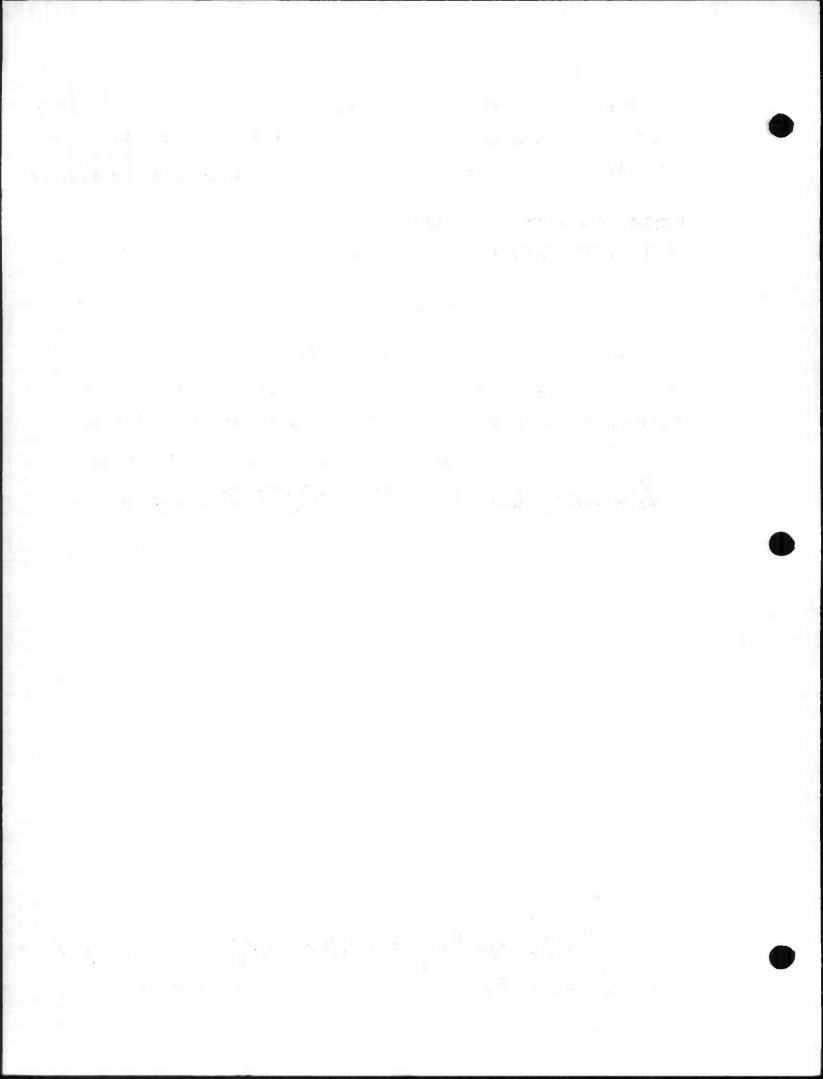
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			1. Decedent's N	ame (First, Middl	e, Last)								2. Dete of De			.L.	3. Tim	e of Death
н	Physic		1	Edith Be	rnai	rdino	Knott						Month	Day		Year 997	2.	37 AM
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	pus *-		10a. State	10b. County			10	c. City, Tow	n or Locatio	nn.						14/	Od Incid	le City Limits
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	23a	<u>a</u>	25180	Sotter:	ly R	load				206	36			USA	4			
	dea	<b>Funeral Director</b>	11. Maritat Statu	ıs		12. Wes De Armed F	cedent Ever	in U,S.	13. Was	Decedent o	f Hispanic O	nigin? (Sp	ecify Yes or No Rican, etc.)		. Race	- America		n,
0	or its	5	1 Never M	larried 2 🔀 Marr	led	1 ☐ Yes	2 X No						riioan, etc.,			White, e	eic.	
21215-0020	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Nems 23a or 28a-f show event, the Medical Examiner must be notified at	by	3 D Widowe	d 4 Divorced		If Yes, G Year or	Dates:		10	Yes 2 N N	o Specify	V:		Sį	oecify:	M	Vhit	e
9	2 ho	Completed		15. Deceden	t's Educ	etion		16a.	Decedent'	s Usual Occ	upation			16b. Kind	of Bus	iness/Ind	lustry	
2	C * W	pie e		pecify only highe: econdary (0-12)	st greae		(1-4or 5+)		life. DO N	Of work dor VOT use reti	ne during mo red)	ist of work	ring					
2	filed within Hygiene. other than ent, the Me	E	Cleriteritary/3	1.2		College	(1-401 5+)			Rank	Telle:	••			Ва	nk		
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7	should be filed within and Mental Hygiene. a marked other than umatic event, the M	F		Name/Relations			LOII,		Mailing A	ddroes (Stro	ot and Mum		len Mae al Route Numb		Town C	Vata Zin	Codel	
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o	t of t		20a. Method of I 1 ☑ Burial	2 Cremation	3 □R	emoval fron	n State	cemete	ry, cremato	n (Name of ny or other p	lace)		Date	20c. Loca	tion - C	ity or To	wn, Stat	ð
Ë	Pan ant:			on 5 Other (S				St. 3	John's	Ceme	tery	6	/26/97	Hol1	Lywo	od,	MD	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of	Funeral Service	License	10			22. Na	me and Add	ress of Feci	lity			_			
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			23a. Part1, Ent	er the disease, or	compli	cetions thet	caused the	death. Do					dtown,		2065	U	Approx	mate
	Dhualaian	V n	shock, or I	neart failure. List	only on	e cause on	each line.				,,						Interval	Between and Death
	Physician /Medical		Immediate Caus	se (Finat			0											
1	Examiner		disease or cond resulting in deal	lition	а		Me	mon	ia							(	me	Week
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	sit ad	Examiner			<b>h</b>		Acut	e mu	1000	rdia	in	Parc	tion			0	me	week
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90	e ex		Sequentially list if any, leading to cause. Enter U Cause (Diseese	nderlying	) .		Dem	untia										
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œ.	raquiras that tha daath een signed by the atte hould be datached for	Physician	Part II. Other sig	nificant conditio	ns cont	tributing to o	death but no	t resulting Ir	the underl	ving cause	given in Part	1.	23b. Dld	tobacco us	e cont	ribute to	the cau	ee of death?
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še	S S S	ldu														of c	death?	
=	Page 1	S											1 🗆	Yes 25	No	1 🗆	Yes	2□ No
Vital	Physician: The this certificate ral director, pag	Be	25. Was cese re examiner?	eferred to medicat	-						26. Plac	e of Deat	h (Check only	one)				
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0 ر			27. Manner of D			28a. Date	of Injury oth, Day Yea		Time of	28c. In	jury et ork?		28d. Describe	how tnjury	occurre	d		
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Division	Attanding ir daath. octor: After by the fune	ific	3 Suicide	6 Could r		28e. Plac	e of Injury -	At home, fa	rm, street, f	factory, offic	8		28f. Location (		Vumber	or Rura	Route I	Vumber,
ă	or Attand after death Director: A	Certification:	4 Homicic	10		build	ling, etc. (S	pecify)					City or To	wn, Stete)				
	To the Hospital or Atta within 24 hours aftar da To the Funeral Directo completely filled in by th		29a, Certifier	1□ Certifyin	n Physi	Iclan: To the	e hest of my	knowledge	death occ	urred at the	time date a	nd place	end due to the	cause(s) ar	nd man	nor se et	nted	
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			30. Name and a	dress of person						)						•		
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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1, Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** Yaar June 5. Keffer 2:55 PM William Tsaac /Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, give street and number) 4c. County of Death Examiner St. Mary's 24316 Mervill Dean Road Hollywood If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5 Social Security Number 7. Age (In yrs. last birthday) Birthpiace (Stata or Foreign Country) **Funeral** 1⊠M 2□ F 179-24-5857 Yrs 73 Director Feb 29, 1924 Pennsylvania Usuai Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 TNo Directo Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 24316 Mervill Dean Road 20636 U.S.A. Funeral 12. Was Decedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spacify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, atc. 1 ⊠ Yas 2 □ No If Yes, Give Yaar or Dates: 1941–1962 1 Nevar Married 2 Married 1 ☐ Yes 2 Ø No Specify: White þ Specify: 3 Widowad 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) 12th Grade Aviation Jet Mechanic U.S. Navv 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumama) Keffer Joel Ellen Pearl Huey 2 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Dorothy R. Keffer/Spouse 24316 Mervill Dean Rd., Hollywood, MD 20636 20b. Placa of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cramation 3 ☐ Removal from State 6/9/97 Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20650 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaase or condition resulting in death) Examiner Examiner physician and tha burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequent Division of Vital Records, P.O. Box 68760. Physician/Medicai Due to (or as a consequence attanding usa ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ata has been signed by tha a paga 2 should be detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? Aftar this cartificata has 1 Tes 1 ☐ Yes 2 ☐ No al or Attending Physician: To saftar death.

I Director: Aftar this carificated in by the funeral director, ps 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury at Work? 1 Natural 2 Cocidant 5 Panding 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) complataly filled In by 4 Homicida To the Hospital of within 24 hours a To the Funeral D 11 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of o 29c. Licensa number 29d, Date signed (Month, Day, Year) se of death (Item 25a) (Type, Print) 30. Name and address of p 20650 Patrick Jarboe Leonardtown, MD 31. Date filed (Month Day. 32. Registrar's Signature State



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Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Grace Keleti 8:07 a.m. June 24, 1997 /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner 6003 84th Avenue New Carrollton Prince George's If Under 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 N F 63 Yrs Director 215-34-7695 Sept. 17,1933 North Carolina Usual Residence of Deceden the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic svent, the Medical Examinar must be notified at 1⊠ Yes 2□ No Director Maryland Prince George's New Carrollton 10e. Street and Number 10f. Zip Code 10g, Citizan of What Country? 6003 84th Avenue 20784 U.S.A death Funeral 12. Was Decedent Ever in U,S Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mantel Hygiena. If them 27 is merked other than "natural", or iter any injury or other traumetic avant. 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Datas: Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: American Indian þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumame) McKinley Locklear Sallie Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen L. Keleti - Spouse 6003 84th Avenue, New Carrollton, Maryland 20784 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ₺ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 06/27/97 Clinton, Maryland 22. Name and Address of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Entar tha disease, o complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Pneumonia Days Examiner Due to (or as a consequenca of): Aspiration Days that the death certificate be axecuted buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of): Records, P.O. Box 68760. ettending physician for use as the burie 2 Days Hypoxic Encephalopathy Physician/Medical Due to (or as a consequenca of): Ischemic Heart Disease Years signed by the et d be datached for Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 Yes 2 NO No 1 ☐ Yes 2 🖾 No certificata Division of Vital Hospital or Attending Physician: 24 hours efter deeth. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 🛭 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director 3 Sulcide 6 Could not be in by t 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours the Funeral Directory 4 Homlcide 1⊠ Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.

2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certillo Medical юmpietaly To the I 29b. Sit 29c. License number 29d. Data signed (Month, Day, Year) D22780 June 25, 1997 30. Name and address of per mon who completed cause of death (Item 23a) (Type, Print) Peter M. Schissler, M.D. 7500 Greenway Center Drive #430, Greenbelt, Maryland 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 27 1997

Statement in the California

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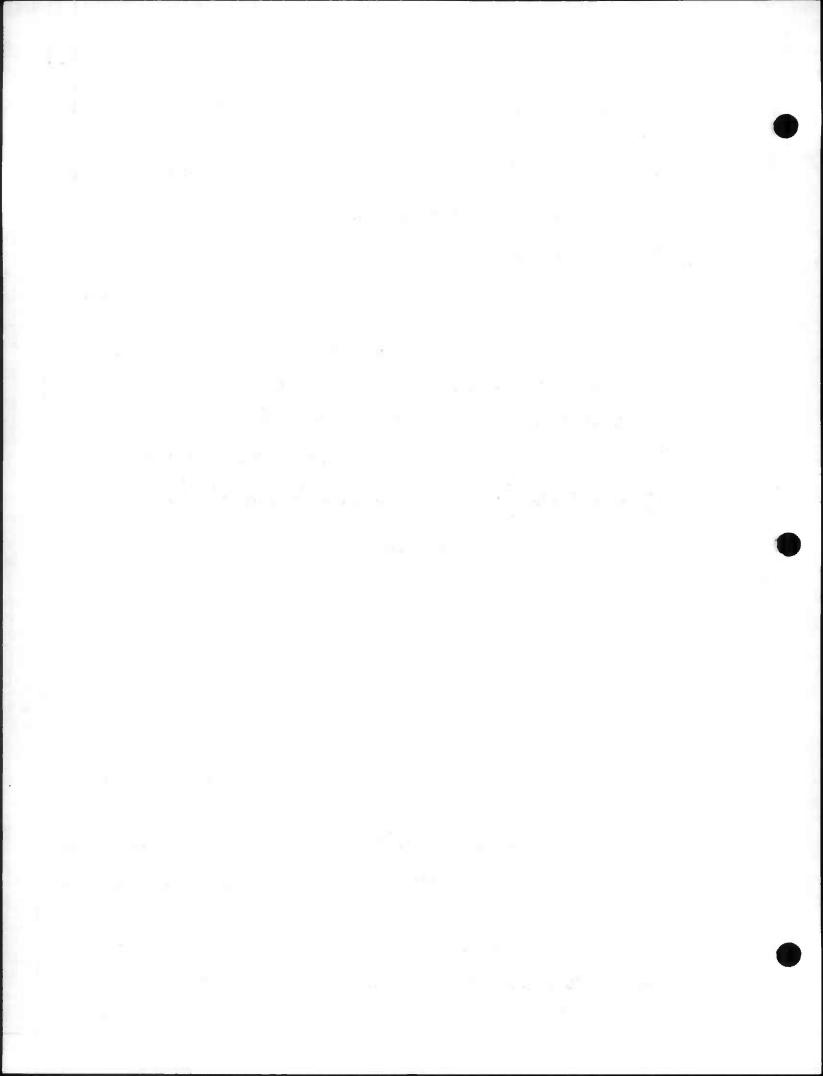
Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Daeth 3. Time of Death **Physician** 20, 1997 Virginia Kay June 5:30 A.M. /Medical 4a. Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Magnolia Gardens Nursing Home Prince George's Lanham 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dela of Birth (Month, Day, Year) **Funeral**  Birthplace (Steta or Foraign Country) Months Days 1□M 2□F Hours 324 30 0729 82 Director April 15,1915 Illinois Usual Rasidanca of Dacadant permit. Pages 1 and 2 should be filed within 72 hours efter death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f show any Injury or other traumetic event, the Medical Examinar must be nutified as 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Prince George's Maryland Glenn Dale Director MXYas 2□ No 10a. Street and Number 10f. Zip Code 10g. Citizan of What Country? 12016 Augusta Drive 20769 Funeral United States Raca - American Indian, Black, Whita, etc. 12. Was Decedani Evar in U,S. Armed Forcas? 13. Was Dacedant of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) I □ Yes 2√No If Yas, Giva Yaar or Datas: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas & No Spacify: þ Specify: White Widowad 4 □ Divorcad Completed 15. Decedant's Education (Spacify only highest grada completed) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 Homemaker Own Home 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Be Harry Hero 2 Gertrude Johnson 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Route Number, City or Town, State, Zip Coda) Harry G. Kay Son 12016 Augusta Drive Glenn Dale Maryland 20769 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Steta Data 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Metropolitan Crematory June 21, 1997 Alexandria Virginia 21. Signature of Fundral Service Co. 22. Nama end Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 23a. Parl 1. Enter the disaese, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiretory arrast, shock, or heart failure. List only one gause on each line. **Physician** /Medical Immediata Causa (Final Cerebrovascular disaasa or condition rasulting in daath) Examiner Due to (or es a consequança of) Examine or Attending Physician: The lew requires that the death certificate be executed the bunal-transit Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disease or injury that Initiated avants rasulting in daath) Last Dua to (or as a consaguança of) Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): for use es Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. director, page 2 should be detached 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Wara autopsy findings availabla prior to complation of cause of daeth? 24e. Wes an autopsy performad? After this certificete hes 1 Tyes 2 No 1 ☐ Yas 2 ☐ No Be 25. Was case rafarred to madical 26. Placa of Daath (Check only one) axaminar? To the Hospital to within 24 hours after death.
To the Funeral Director: After this commendately filled in by the funeral directors. 10 Othar: 4 Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) Certification: 27. Manner of Daath 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Matural 5 Panding Invastigation 1 □ Yas 2 □ No 2 Accidant 3 Suicida 6 Could not be datarmined 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicida 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian Medical (Check only 29b. Signatura and titla of cartified 29c. License numbar 29d. Data signed (Month, Dey, Yaar) MO D35820 8 30. Name and address of person who complated druse of death (Itam 23a) (Type, Print) BOWE, MO cleben 14300 Gallant Fox Lane #110 20 31. Data filed (Month, Day, Year) 32 Ragistrer's Signatura State JUN 24 1997 Registrar

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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 21061

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п	Physici	an	Decedent's Name (First, Middle, La						2. Date of Dee Month	th Day	Yeer	3. Time of Deeth
4	/Medi		Debra Jean K						JUNE	21, 199		2:17AM
	Examir	ner	4e. Facility Neme (If not institution, given MARYLAND RTE# 32				4b.	City, Town, or Lo		4c. County	of Deeth	
	Funeral Director		5. Social Security Number 6. S 214-84-5103 Usual Residence of Decedent		In yrs. last birtho	Months		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 7,	1962	9. Birthpled Country Mary	ce (Stete or Foreign Vland
	ehow		10a. Stete 10b. County	1	Oc. City, Town o	or Location					10d	d. Inside City Limits
	a-f el	ctor	MD Carroll	L	Sykes	ville	~ 0.					1 ☐ Yes 2 ☐ No
	with the	I Director	10e. Street end Number 4227 Jim Bowers	s Road		10f. Zip	Code 21784		1	0g. Citizen of V		n
020	filed within 72 hours efter deeth with the Meryland Hygiene. uther than "natural", or items 23a or 28a-f ehow ent, the Medical Examiner must be not filed at	by Funeral	11. Marital Status  1 ☒Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ev Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	er in U,S.	13. Wes Dece if Yes, spe- 1 \(\superstack Yes\)		penic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rac	e - American k, White, etc	c.
2-0	72 ho natura	sted	15. Decedent's E. (Specify only highest gra	ducetion	16a. D	ecedent's Usua	el Occupeti	on ring most of work	ina	16b. Kind of Bu	usiness/Indus	stry
121	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemal		ing most of work	ing .	Dor	mestic	
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/lar	should be ind Mentel I	ToB	Henry Edwar	d Kraus, Ji	- ·			Cath	erine O	. Malon	е	
, Maryland 21215-0020	C/ 4 = 62		19a. Informent's Name/Relationship ( Mr. Henry Kraus,					art, Wes				ode)
Baltimore,	permit. Peges 1 end Department of Health Important: if Item 27 any Injury or other tr 900.9.		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donetion 5 □ Other (Specify		20b. Piace of D cemetery, Meadow	cremetory or o	other place)	etery 6		20c. Location - Vestmin	•	
Balt	permit. Depending		21. Signature of Funeral Servica Licer	Just to				RAL HOME MD 2178				
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	Physician /Medical Examiner		Immediate Ceuse (Final disease or condition	Mult	iple In	juries						Inset end Deeth
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Vita	Physician: The this certificate rel director, per	Be	25. Wes case referred to medical examiner?	Hospital:			1	6. Plece of Deetl	(Check only or	e)		
	Phys this rel di	n: To	YYes 2□ No 27. Manner of Death	1 ☐ Inpatient 28e. Dete of Injury	28b. Tim	ne of 2	OA Other: 28c. Injury e Work?	4 INUISING HO	me 5 Reside		er (Specify) red	SCENE
ion	Attending I or death. octor: After by the funer	atio	1 ☐ Netural 5 ☐ Pending 2 🖾 Accident Investigation	(Month, Day Y	eer) Inju	TOUL		s 2 <b>N</b> No	motor v	rehichle	e acci	dent
Division	al or Attending s efter death. I Director: After id in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Placa of Injury building, etc. (	- At home, farm	, street, factory	y, office		28f. Location (S	reet end Numb	er or Rurel F	
	To the Hospital or Attent within 24 hours efter death To the Funeral Director: completely filled in by the	edlcal C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysicien: To the best of r niner: On the basis of ex end manner state	ny knowledge, d amination end/o	eeth occurred	et the time, , in my opin	dete end plece,	end due to the c	ause(s) end ma	nner es stete	ed.
	To the within 2 To the comple	Me	29b. Signeture and title of cartifier			290	c. License n	umber	2	9d. Date signed	d (Month, De	y, Year)
			Noneld &	I Wright A	10		O.C.	M.E.		JUNE 21	, 1997	
			30. Name end address of person who				D-111		24224			
			Dennis J. Chute, 31. Dete filed (Month, Day, Year)				Balti	more, M	21201			
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Death **Physiclan** Elizabeth Month Kelly July Ann 2Am 1997 /Medical 4e. Facility Neme (If not institution, give street end numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Center LaPlata Charles 5. Social Security Number 043-24-5653 7. Age (In yrs. lest birthday) 66 Yrs. if Under 1 Yeer If Under 24 Hrs. 8. Date of Birth Mappin (1947, 12a) 1931 Eountry) **Funeral** 1□ M **¾**□ F Deys Hours Director CT. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mantal Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantinar must be notified at any Injury or other traumatic event, the Medical Evantinar must be notified at any Dines. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Charles Indian Head Funeral Director 1 ☐ Yas 2 No 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code 20640 4 Fairmont Pl. 12. Was Decedent Ever in U,S. Armed Forces? 11 Maritel Status Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indien, Black, White, etc. 1 Navar Married 2 Merried 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Dates: Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: White by 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grede comp 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry completed) Elementery/Secondary (0-12) College (1-4or 5+) Restaurant Waitress 17. Fether's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Clifford Hedin Mary Bukavesky Hedin 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Claire Dawson/Daughter P.O. Box 265 Ironsides.MD 20643 Baltimore, 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cramatory or other place) 20c. Location - City or Town, Steta 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 7/1/97 Alexandria, VA Metropolitan Crem. 21. Signeture of Funerel Sarvice Licensee AREHART-ECHOLS FUNERAL HOME.INC. MO0945 P.O. Box 567 LaPlata, mD 20646 23a. Pert1. Enter the disaase, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heer feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death Physician Immadiate Ceusa (Final diseese or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of): Hospitat or Attending Physician: The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequen-Records, P.O. Box 68760, Physician/Medical the Due to (or as a consequence of): ettending I for use es Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. been signed by the should be deteched 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown þ Completed 24b. Wara autopsy findings evailabla prior to completion of cause of deeth? 24a. Was en eutopsy performed? certificate has blirector, page 2 s 2 No Division of Vital 1 ☐ Yes 2 ☐ No funeral director. Be 25. Was cese referred to medical examiner? 28. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 0 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this 27. Mennet of Death Certification: 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how Injury occurred Aftar 5 Pending investigation 1 Statural 2 Accident 124 hours efter death.

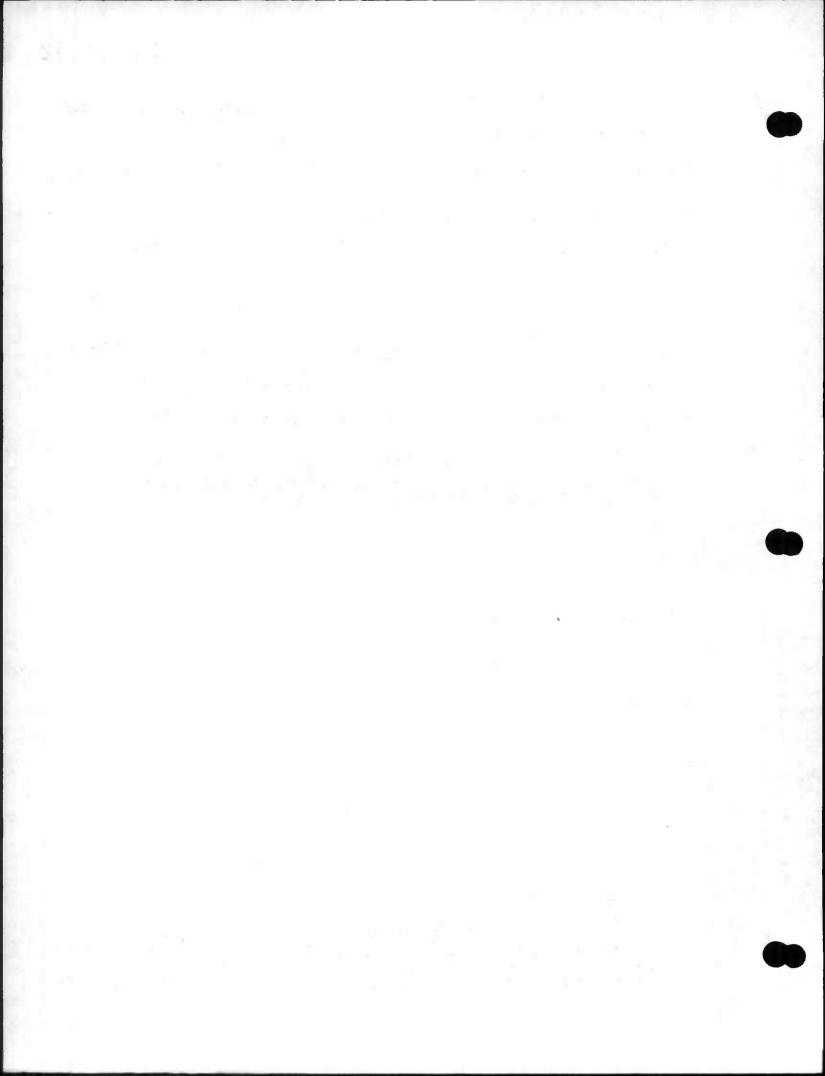
• Funeral Director: After the function by the function of the function 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) and menner as steted.

Medical Examiner: On the basis of exemination end/or investigation, in-my opinion, death occurred et the time, date end place, and due to the cause(s) end manner stated. 29e. Certifier within 24 hor To the Fune completely fi ţ 10 29b. Signatura and life of certific 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 31. Date filed (Month, Dey, Year) Registrar's Signetura State JUL 02 rulia Davideor-Randal

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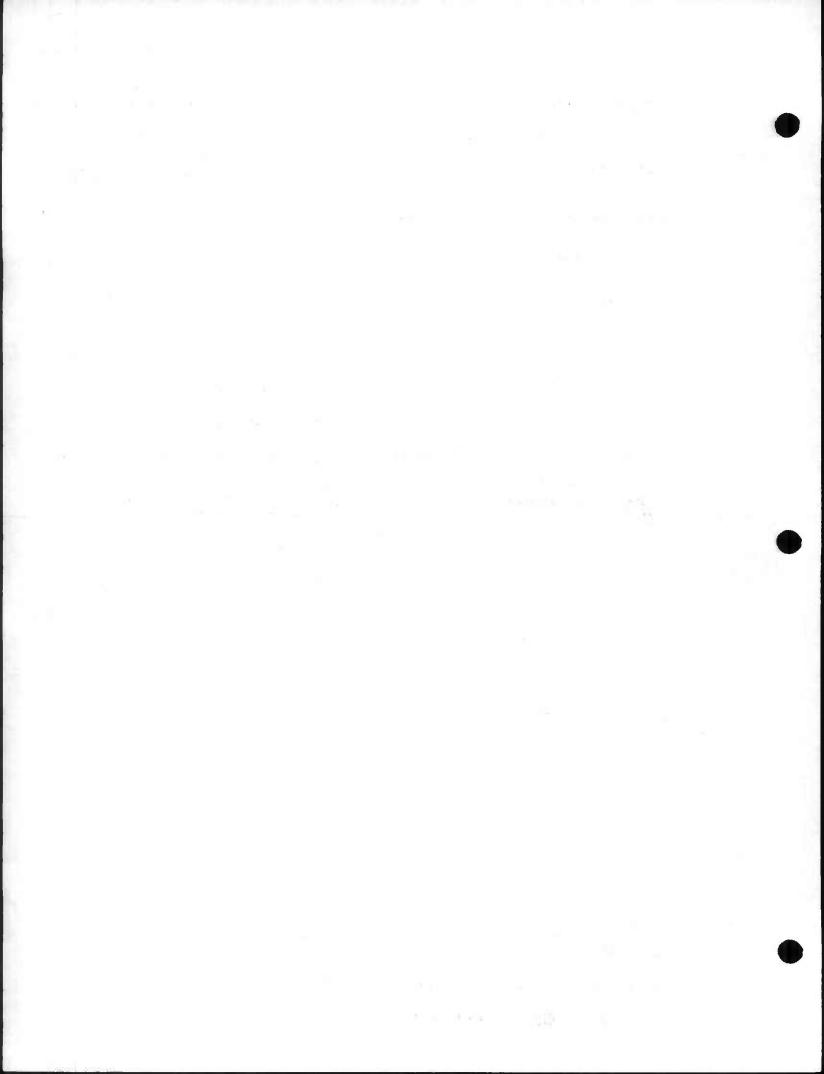
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		30. Name end eddress of person	who completed cau	se of death (Ite	m 23e) (Type,	Print)							
		D. Gregg Oliv	er, M.D.	503 Du	tchman	's Lane	e E	aston	, Ma	ryland	21601		
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DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Daeth 3. Time of Death Month **Physician** Yeer BURON Lamon Landrum 808 pm Baby Boy Revels 1997 June 16 /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Hedical Centar Baltimore Balli moiz If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociei Security Number 7. Age (In/grs. lest birthday) Birthplaca (Stete or Foreign Country) **Funeral** 1**X**M 2□ F Yrs. Director 06-14-9 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show Mor cester 1 Yas 2 No Director ocemoke 10e. Street end Number 10f. Zip Code 10a, Citizen of What Country? 21851 .auvol items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 11. Maritel Stetus 13. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 ծ 1 Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced "natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry dary (0-12) Hygiene. College (1-4or 5+) permit. Peges 1 end 2 should be filled wir Depertment of Health end Mentel Hygiens Important: If ham 27 is markad other tha any Injury or other traumstic event 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumama) Be Lamont andrum Ilmika 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) mother 515 Lauro 1 ST. 1:mika Kevol tocomoke C MD ocation - City or Town, State 20b. Piece of Disposition (Name of cemetery, crematory or othar placa) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) MT. Sian; Comodely O comoku 62. Nama and Address of Fecility Anthony E. Ward Fu 30639 Hampden Ave. 21. Signeture of Funaral Service Licensee MD.21853 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one ceuse on each line. Approximete intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) e. Septic Shock 8 hours Examiner Due to (or as e consequence of): Bacterial SEPSIS Presumed physician and s the buriel-trensit UNKNOWN The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieled events resulting In deeth) Lest Due to (or es a consequence of) Box 68760. Physician/Medicai Due to (or es a consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown signed b Prematurity (30 HKS gestation) Be Completed by 24e. Wes an autopsy performed? 24b. Were eutopsy findings avellable prior to completion of ceuse of deeth? been respiratory distress syndrome pege 2 1 Yes 25 No 1 🗆 Yes 2 No anemi a Division of Vital al or Attending Physicien: The effer death.

I Director: After this certificate of in by the funerel director, pe 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospitai: 1 Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑Nnpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At homa, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours eff To the Funeral DI completely filled in 15 Certifying Phyelcien: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner as stated.

2 Medicat Exeminer: On the bests of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and dua to the ceuse(s) end manner steted. 29a. Certifier Medicai 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) June 16, 1997 D39805 hede wo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Bayview Medical Center Christiane Theda M.D. Dept. of Neonatology 4940 Eastern Ave, Baltimore Hd 21224

9 1997 Julia Dhuclen Rardell

State Registrar

31. Dete filed (Month, Day, Year)

Y 50 00 00 00 1 verlann.l Select red care for 148. E. 127 January W. D. Law and M. Carlon March 1881 Community CONTRACT PROPERTY AND ADMINISTRATION OF THE SECOND PARTY 

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

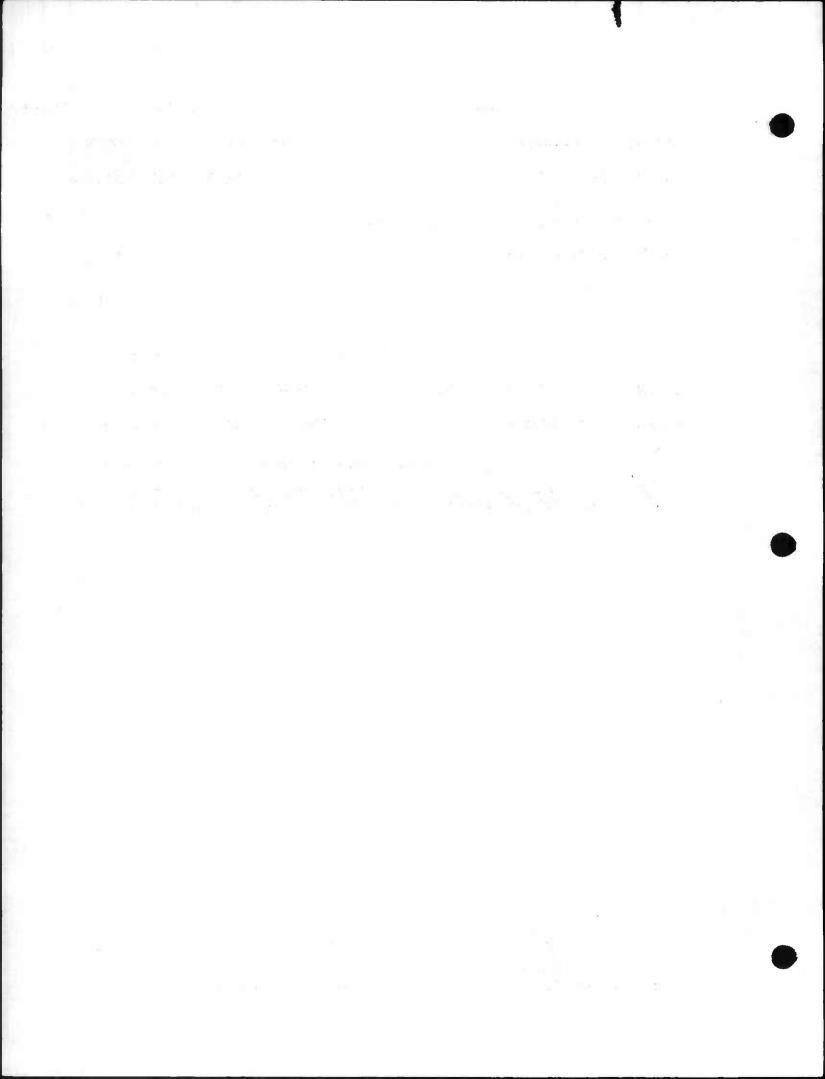
State of Maryland / Department of Health and Mental Hygiene 9 1 2 1 0 6 5

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		Ronald L. Leonar	rd S	on	P.O.	Box 31	16,	Calif	orni	ia, Mar	land	20619		
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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible 2 | 066 State of Maryland / Department of Health and Mental Hygiene

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Phys /Me	ician dical	James	Melvin		Long		May 27		1001	5:00 P.
*	niner	4e. Facility Name (If not institution, giva	street and number)			4b. City, Town, or	Location of Death	4c. County	of Death	
		St. Mary's Hospi	tal			Leonardt		St.	Mary's	
Funer Directe		5. Sociel Security Number 6. Sec. 577-09-2581 Usual Residence of Decedent	7. Age (in y	rs. lest birtha Yrs	Months D	ear if Under 24 Hr eys Hours Mir		, Year)	9. Birthple Country Maryla	ce (State or Foraign y) and
show of at		10a. State 10b. County	10c.	City, Town o	r Location				100	d. Inside City Limits
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20 s after dee or items	by Funeral Director	11. Maritel Stetus  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever In Armed Forces? 1 → Yes 2 → No If Yes, Give Yeer or Detes:	U,S.	13. Wes Decedent If Yes, specify 1 ☐ Yes 2 ☒	of Hispanic Origin? ( Cuban, Mexican, Pue No Specify:	Specify Yes or No- rto Rican, etc.)		e - Americar ck, White, et	c.
72 hours natural.	3	15. Decedent's Ed	ucation	16a. De	ecedent's Usuel O	ccupation	T	16b. Kind of B	usiness/indu	stry
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Maryland d 2 should be file th end Mental Hy 7 Is marked othe traumatic event	-	19a. Informant's Neme/Reletionship (7	ype, Print)	19b. M	eiling Address (S	reet and Number or F	Rural Route Numbe	r, City or Town,	Stata, Zip C	ode)
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Or VICAL new Physician: The lev this certificate hes ral director, page 2	Be	25. Wes case referred to medical examiner?				26. Place of De	eth (Check only or	тө)		
Physic Physic this ce	70	1 Yes 2 No	Hospitel: 1 Inpatient 2	☑ ER/Outpe	tient 3 DOA	Other: 4 Nursing	Home 5 ☐ Reside	ence 6 Oth	er (Specify)	
I O Pt		27. Menner of Death 1 Natural 5 □ Pending	28e. Dete of Injury (Month, Day Year)	28b. Tim	e of 28c.	Injury at Work?	28d. Describe h	ow injury occur	red	
To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th complately filled in by the funeral	Certification:	2 Accident 3 Suicide 6 Could not be 4 Homlcide	28e. Pleca of Injury - At building, etc. (Spe	home, ferm.	М	1 ☐ Yes 2 ☐ No	28f. Location (S City or Town	treet and Numb n, State)	per or Rural F	Poute Number,
n 24 hours n 24 hours ne Funeral	edicai	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Example 1	elclan: To the best of my k ner: On the basis of exemi end menner stated.	nowledge, de netion end/o	eeth occurred et the rinvestigation, in	ne time, dete end plec my opinion, death occ	a, end due to the courred et the time, d	ause(s) and ma lete end piece,	anner as stat and due to th	ed. he cause(s)
To the To the To the Comp	×	29b. Signature end title of certifier			29c. Li	cense number	2	9d. Date signe	d (Month, De	ay, Year)
		· gar	20		D2	3634		May 3	0, 199	7
(4)		30. Name and address of person wheel		em 23a) (Ty	pe, Print)					
(3)		Adinath A. Patil,			Leona	rdtown, MD	20650			
5	tate	31. Date filed (Month, Day, Year)	33 Registrar's Sig	inature	all.					

DHMH 16 Rav 6/95



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State of Maryland / Department of Health and Mental Hygiene 97 21067

				,		Certificate of		Worker 11	Reg. No.	7 6a	.007
	Physic /Medi Exami	cal	Dacedent's Name (First, Middle, Li     Pacific Name (If not institution, girls)	L be	NIS	> 0 /	4b. City, Town, 9	2. Date of Do Month Location of Daa	Day	Year 7	3. Time of Death
	Funeral Director		343-23-7200	A OC/2 / NASA (In your 10 M 2 F 39		day) If Undar 1 Year Months Days	If Under 24 Hr Hours Mir		irth 1957	9. Birthpla Country Califor	ce (State or Foreign
	the Maryland 7 28e-f show	tor	Usual Residance of Decedent  10a. Stata 10b. County  Maryland Calver		City, Town	or Location				100	1. Inside City Limits 1 Yes 2 No
	th with the 23a or 28e unt be not	Funeral Director	10e. Street and Number Simpson Farm Road	, 8791		10f. Zip Code 20736			10g. Citizen o	f What Country States	
020	after des	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decadent Ever in Armed Forces?  1 ■ Yes 2 □ No if Yes, Give 1976—		13. Was Decedant of Int Yes, specify Cub		Specify Yes or Norto Rican, atc.)	o- 14. R B	aca - Americar tack, White, et cify: Whit	c.
21215-0020	within 72 hours ens. than "natural",	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 1 2	ducation ede com <i>pleted)</i> College (1-4or 5+)	- '	Decedent's Usual Occup Give kind of work done life. DO NOT use retire urity Spec	during most of wo d)	orking	16b. Kind of U.S. De	Business/Indu	stry
Maryland 2	2 should be filed withir end Mental Hygiene. le marked other than eumatic avant, me M	To Be Co	17. Fathar's Name (First, Middla, Last Harvey Lee lewis	)	Dec	dilly bpec	18. Mother's Na	ame (First, Middle lackwell	, Maidan Suma		
lan	2 short and N le mainte		19a. Informant's Name/Relationship	Type, Print)	19b.	Mailing Address (Straet	end Number or F	Ru <i>ral Rou</i> te Numb	oer, City or Tow	n, Stete, Zip C	ode)
Baltimore, N	permit. Peges 1 end 3 Depertment of Health mportant: If Item 27 I any Injury or other tr. 2059.		Jason Robert Babcock,  20a. Method of Disposition  1 □ Burial 2 ■ Cremation 3 □  4 □ Donation 5 □ Other (Specia	Removal from State	Place of l	36 Pinto Drive Disposition (Name of crematory or other ple itan Crematory	ca)	Date		- City or Town	
Balti	permit. Pege: Department or Important: If I any Injury or		21. Signature Funery Service to Edward N. Brinsti	1509	-	22. Name and Addre	ess of Facility Bri				0-0279
			23a. Part1. Enter the disease, or com shock, or heart failure. List onty	plications that caused the de ona cause on each line.	ath. Do-no	ot enter the mode of dyir	ng, such as cerdia	ac or respiratory	arrest Strice	A	pproximate iterval Betwaan
	Physician /Medical Examiner		Immadiate Cause (Final disease or condition resulting in death)	. Brain	D	QAHA		9	Registration of the second		Onset and Death
	cuted nd rensit	Examiner	Sequentially list conditions.	. BAIN	(or as a co	PONIATO	ew)	Confession .			12 hr
68760,	deeth certificate be executed e ettending physician and ed for use es the buriel-trensit		Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Cerebra	(or as a co	Edemo	+	/			1/2 hr
Box 6	eeth certifica ettending ph I for use es t	Physician/Medical	Last Committee in	. CAPDON		lonoxic	Of Pe	OCON	M	<	23hs
P.O. I	that the dee ned by the el deteched fo	ysic	Part II. Other aignificant conditions of	ontributing to death but not re	sulting in	he undarlying ceuse giv	en in Part t.	23b. Did	tobacco use o	ontribute to the	na cause of death?
	w requires thet to been signed by should be determined.	þ	CAMONIC	Depres	MON	]		10	Yes 2000		
of Vital Records,	hes pe 2	Completed						24a. Was perfe	an autopsy ormed?	availa	autopsy findings abla prior to eletion of cause eth?
ta		Be Co	25. Was cese referred to medicat				OC Plans of Da	1 🗆		1 🗆 Y	'es 2□ No
Ϋ́	97	To B	examiner? 1,⊠ Yes 2 □ No	Hospital: Inpatient 2	☐ ER/Outp	atient 3 DOA Oth	er: _	eath (Check only only only only only only only only		thar (Specify)	Jenes I
Division o	i or Attending Phy efter death. I Director: After this d in by the funerel d	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not by	0/0/66		28c. Injur Wor 1		Vehiclo R	how injury occi	Garage	
Div	To the Hospital or Al within 24 hours effer To the Funeral Dirac completely filled in by		4 Homicide determined	building etc. (Spec	0	n, sfreet, factory, office		87915	MOSON	JFAM	ROAD
	n 24 h	edical	(Check only 2 Medicei Exan	ysician: To the best of my kr ninar: On the basis of examir and manner stated.	ation and/	or Investigation, In my o	ne, date and plac pinion, death occ	e, end due to the urrad at the time,	date and place	enner as state , end due to th	e ceuse(s)
	To the To the To the Company	M	29b. Signature and title of certifier	Remo	Coor	29c. Licens	e number 7163		29d. Date str	Manth, De	y, Yeer)
		À	30. Name and oddress of person who R.A. OWLET Sho	completed cause of death (the	230 T	/ 225. (	Greent	St. 13	Alten	urp 1	1d zror
	Sta Registr		31. Date filed (Month, Day, Yaer)  JUN 0 9 199	32. Registrar's Sign	Rardo	Ц					

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State of Maryland / Department of Health and Mental Hygiene 1 2 1 0 6 8

	Item:5	per	r FH G-749 7/10/97 dh State of Maryland / Depar	riment of F ificate of		, ,	giene /	C. I	000
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  GERTRUDE A	MOLS	TER	2. Date of Dea Month	th Day	Year 997	3. Time of Death
	Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L		4c. County		
	Funeral Director		677 T0 9393 10 M 2/24 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey SEPT. 3,	MONTG		ace (State or Foreign try)
	land w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Local	ation .	-			10	Od. Inside City Limits
	Mary a-f eh	tor	MD. MONTGOMERY MONTGOMER	Y VILLAG	GE.				1 Yes 2 No
	or 28	Director	10e. Street and Number	10f. Zip Code		1	10g. Citizen of V	Vhat Count	ry?
	s 23a	erai	8313 FRONTWELL CIRCLE		20879		UNITED		
020	72 hours efter death with the Maryland netural; or items 23a or 28a-f show deal Examiner must be notified at	by Funeral	3 ⊠Widowed 4 □ Divorced If Yes, Give Year or Dates:	as Decedent of F Yes, specify Cub ☐ Yes 2 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	Specify	e - Americe ck, White, e : WHI	etc.
21215-0020	- 4 30	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)		pation during most of work d)	ing	16b. Kind of Bu		ustry
d 2	filed v Hygie other 1		12 4 HOMEM	AKEK	18. Mother's Nam	e (First, Middle,	OWN H Maiden Sumam		
/lan	s should be filed within end Mental Hygiene. s marked othar than aumatic event, the Me	To Be	SELDEN W. ANDERSON		GERTRUI		BURD		
, Maryland	1 and 2 sho Health end I ism 27 is ma other trauma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing		end Number or Rui				
Baltimore,	ges 1 of He If Itam or oth		20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3 □Removal from State  20b. Place of Disposicemetery, cremation	tion (Name of atory or other pla	ce)	Date	20c. Location -	City or Tov	vn, State
Iţim	permit. Pages i Department of H important: if its any injury or ot once.		4 Donation 5 Other (Specify) METROPOLI					RIA,V	IRGINIA
Ba	Depa Impor any Ir				SS BARBER 1 5038, LAY			2088	32
	2000		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	The mode of dying	ng, such as cerdiac	or respiratory are	rest,	1	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	/ /	1em,	9		1	UNKNOWN
	Do ##	iner	Dubb to (or as a consequence of the second o	ence of):					L W PEK
Bh.	ficata be executed physician end s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or Injury c.	ence of):					
68760,	ta be e ysiciar ne burià	edicai E	Cause (Disease or Injury that initiated events	ance of):		_			
	entifica ing ph e as th		resulting in death) Last						
Box	ath ce attend for us	sian/	d						
P.O.	requires that the death_certificate be executed seen signed by the attending physician end hould be detached for use as the burial-transit	Physician/M	Part II. Other eignificant conditions contributing to death but not resulting in the unc	lerlying ceuse giv	ven in Part I.	23b. Did to	/		the cause of death?
	Se un equ	by	3-6/5/3					- At 14.	F. F.
Records,		ietec	HYPOTENSION			24a. Was a perfor	n autopsy med?	ava	re autopsy findings ilable prior to npletion of ceuse
	2 5 0	Completed	BRAdy CARVIA			1 🗆 Y	es 2 No		leath? ]Yes 2□ No
Vital		Be C	25. Was cese referred to medical examine 2		26. Place of Deat	h (Check only or	ne)		
of\	Physician: this certific ral director,	. To	1 Dres 2 No Hospital: 1 Dimpatient 2 ER/Outpatient	3LI DOA		ome 5 Resid			)
	Fing After fune	tion	27. Manner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation  28a. Date of Injury (Month, Day Year)  Injury  28b. Time of Injury	28c. Inju Wo M 1 □	rk? ]Yes 2□No	28d. Describe h	ow injury occur	90	
Division		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office		28f. Location (S City or Tow		er or Rura/	Route Number,
	To the Hospital or Attend within 24 hours aftar death To the Funeral Director: completely filled in by tha	edicai C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death of the control o	occurred at the til stigation, in my o	me, date and place, opinion, death occur	and due to the c red at the time, o	ause(s) and ma date and place, a	nner as sta and due to	ated. the cause(s)
	Vithi To #	×	29b. Signature and titlerof certifier	29c. Licens	se number	2	29d. Date signe	d (Month, E	Day, Year)
			" muggalle, or	7 2	_0 5-Ce	2	JULY	02	11997
			30. Name and address of person who completed ceuse of death (Item 23a) (Type, Pr	Fer	NWOOL	ROA	d 136	the	sda md
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

#### Please Type or Print in Riack Indelible Ink. Accure All Copies Arel maible 1 0 C 0

						Cer	tificate o	f Death		Re	g. No.		
ysician		Decedent's Nam							2. Dat Mo	e of Death	Day	Year	3. Time of Death
/ledical		Carl J.										997	0835 AM
aminer	1	4a. Fecility Name (/ I – 95	lf not institutio	on, give street end nur	n <i>ber)</i>			4b. City, Town, HAVRE			4c. Count		
	4	5. Social Security N	lumber	6. Sex	7. Age (In yrs.	lest hirthday)	If Under 1 Yea				HARI		leas (Ctata as Fassian
eral ctor				1 M 2 □ F	48	Yrs.	Months Dey		Vin. (Mo	e of Birth nth, Dey,	Yeer)	9. Birthp	lace (Stete or Foreign try)
		205-36- Usual Residence of			40				Jul	y 10,	1940	Pnila	delphia,
3 .		10a. Stete	10b. County	y	10c. Ci	ty, Town or Loc	ation					1	0d. Inside City Limits
be notified at		PA	Che	ster	Ma	lvern							1 ☐ Yes 2 No
Dire		10e. Street end Nur	mber				10f. Zip Code			10	g. Citizen of	Whet Coun	try?
rai		25 Ther	esa Dr					355			U.S.		
Funeral		11. Marital Status		12. Was Dece Armed Fo	dent Ever in U	,S. 13. V	Vas Decedent of Yes, specify Cu	Hispanic Origina ban, Mexican, P	? (Specify Ye uerto Rican, o	s or No- etc.)		ce - Americ	
by F		1 ☐ Never Marri 3 ☐ Widowed	4.5	If Yes, Giv	e		□Yes 2XN				Specil	y: Whi	te
		3 - Widowed			ates:	100 December	antia Haval Osa	- mation		- 44	Oh Kind of D		t t
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omo:	5	Elementary/Seco	ondary (0-12)	College (1				ecutive			Fina	ncial	
BeC		17. Father's Name	(First, Middle,			, I znan	CIGI DA	18. Mother's	Name (First,	Middle, Ma			
To Be C	1	Carl J.	Melon	e				Clai	ire Swi	itai			
		19a. informant's Na	ame/Relation	ship (Type, Print)		19b. Meilin	g Address (Stre	et and Number of			City or Town	, State, Zip	Code)
SUC#		Barbara	K. Me	lone/ Wife		25 Th	eresa D	r., Malv	vern, I	PA 19	355		
		20a. Method of Disp		0		Place of Dispos	ition (Neme of etory or other p		June	20	Oc. Location	- City or To	wn, State
	1	4 Donation		3 □Removel from Specify)		ladelph	nia Memo	rial Pk		- 1	Fraze	r. PA	
8500	I	21. Signature of Fu	meral Service	Licensee	7 1	22.	Name and Add	ress of Facility				-,	
8		the	hard	7. U	o fin			d Funera een St.				Sun.	MD 21911
	1	23a. Part1. Enter the	he disease, o	r complication lat ca t only one caus on e	aused the deat	h. Do not ente	r the mode of d	vina, such es cer	diac or reenir	etory erres	st,	Dairy	Approximete
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S. Radentz

Penn Street, Baltimore, Maryland 21201 111

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32. Registrar's Signature

State Registrar

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State of Maryland / Department of Health and Mental Hygiene 97 21070

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ModelCal Examiner   Mode		Physician		23a. Part1. Enter the disease, or con- shock, or heartfulure. List only	plications that caused the one cause on each line.	e death. Dor	not enter the mo	ode of dyi	ing, such as cerd	liac or respiretory e	rrest,		Interval Between
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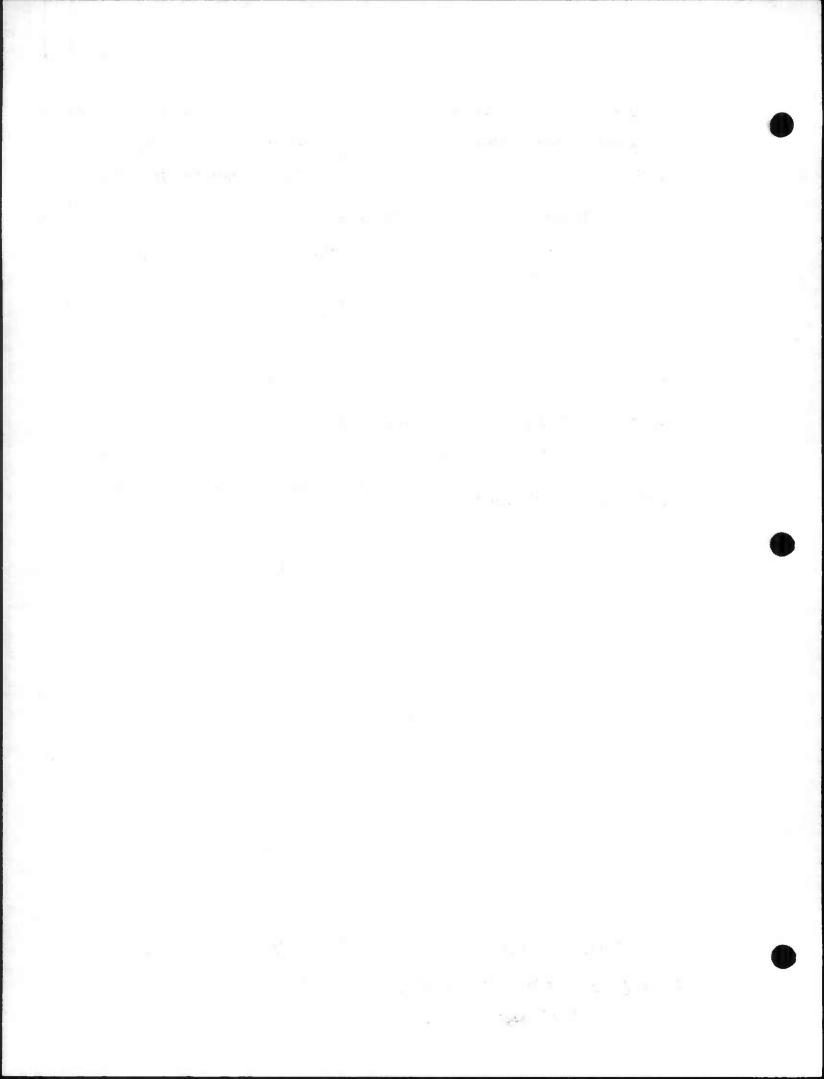
#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Daath 3. Tima of Death **Physician** Month Day Year Bridget Frances McCracken June 25. 1997 6:20 am /Medical 4a. Facility Neme (If not Institution, give straet and number) 4b. City, Town, or Location of Deeth 4c. County of Daath Examiner Solomons Nursing Center Solomons Calvert If Under 1 Year If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Data of Birth (Month, Day, Year) Birthpiaca (Stata or Foraign Country) **Funeral** Months Days 1□M 2♥F Hours 76 Yrs Director 242 20 0154 July 28, 1920 NC Usual Rasidance of Dacedant permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mantel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Mexical Examiner must be notified at once. 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Calvert Port Republic Director 1 Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 3380 Howard Drive 20676 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yes or No-It Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black. Whita, atc. 1 ☐ Never Merried 2 ☐ Married 1 □ Yas 2 □ No If Yes, Giva Yaar or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No þ Specify **3**€ Widowed 4 Divorced white Completed Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondery (0-12) College (1-4or 5+) house wife own home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be Delas C Reece Bertha Burke 2 19a. Intormant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) M. Frank McCracken/ son same as 10 above 20b. Place of Disposition (Nama of comatery, crematory or other place)
Morning Star Cemetery 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 6-28-97 Canton, NC 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service License 22. Name end Addrass of Facility Rausch Funeral Home, Owings, MD 23e. Pert 1. Entar the disaasa, or complications that use of the disath. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart tallura. List only one cause on each line. Approximeta Intarval Between Onset and Deeth **Physician** /Medical Immediata Causa (Final 2-3 yrs diseasa or condition rasulting in death) Examiner OBSTRUGINE PUL. DISEASE Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the deeth certificate be asscuted within 64 hours after death.

To the Funeral Director: After this certificate has been signed by the ettanding physician and completaly filled in by the funeral director, page 2 should be dateched for use as the builet transit Sequantially list conditions, if any, laading to immadiate cause. Enter Underlying Causa (Disaesa or injury that initiated avants rasulting in deeth) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequance of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part f. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown þ 24b. Ware eutopsy findings evailable prior to completion of cause ot death? Completed 24a. Was an eutopsy performed? Arten Druase 1 Tas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa ratarred to medical examinar? 26. Pleca of Daath (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? 28d. Dascribe how injury occurred 1 Natural 5 Pending 2 ☐ Accident investigation 1 ☐ Yas 2 ☐ No 6 Could not be determined 28e. Plece of Injury - At home, tarm, straat, factory, office building, etc. (Specify) 3 ☐ Suicida 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 4 Homicida 12 Certifying Physician: To tha best of my knowledge, death occurred at the time, dete end plece, and due to the causa(s) and menner es steted.

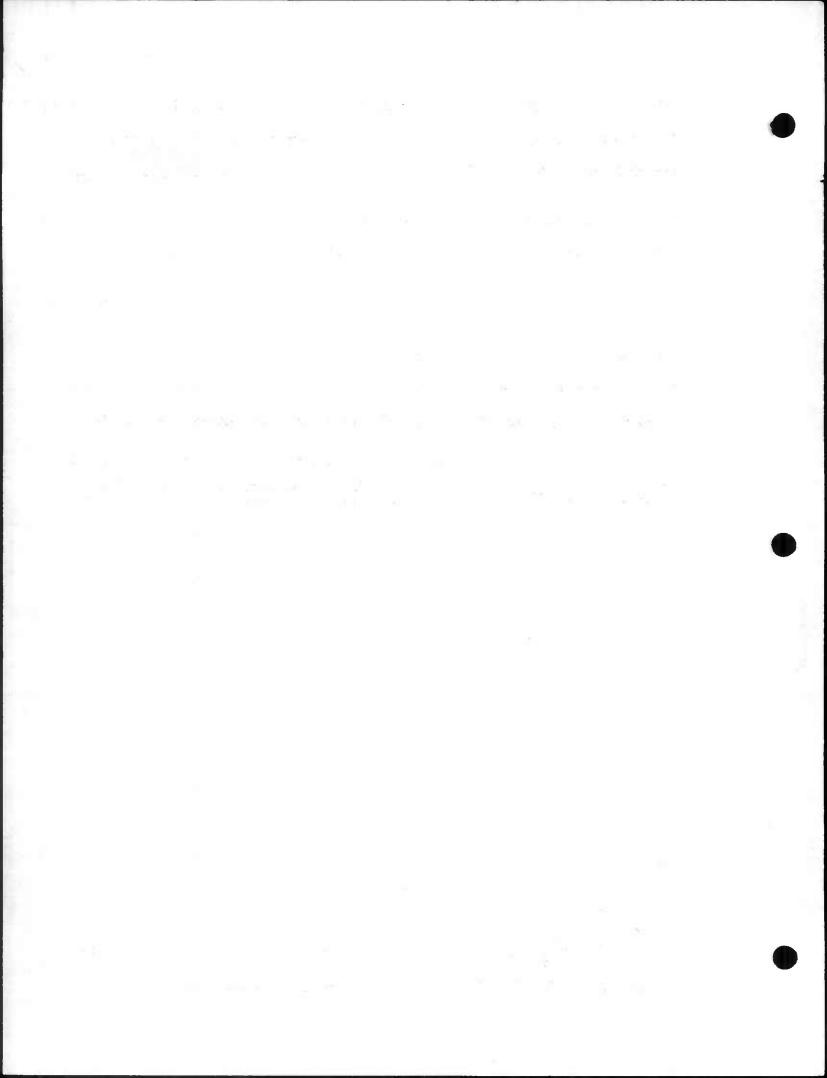
2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data end place, and due to the causa(s) end manner stated. Medicai 29a, Certifier 29b. Signetura and titla of certitian 29c. License number 29d. Dete signed (Month, Dey, Year) atel D50249 MD 30. Nama and address of person who complated cause of death (Itam 23a) (Typa, Print) HUSP DR, PR. FREJERIUK MD 20678 #303, 31. Data tilad (Month, Day, Year)
JUN 27 32. Registrar's Signatura State

1997 > Jalia Davidego Raylall



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						Certifica	te of	Death	Re	g. No.			
	Physic	an	Decedent's Name (First, Middla, Last)						2. Date of Death	-	Year		ne of Death
	/Medi		John Alv		Mat	tingly			June 2,	1997			3:58 P.
	Exami	ner	4a. Facility Nama (If not institution, giva s St. Mary's Hospita					4b. City, Town, or L Leonardt		4c. County St. N		S	
	Funeral Director		213 02 1100	7. Aga (In yr 28		rs. If Unda Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 6		9. Birthp Coun Mary		ata o <i>r For</i> aign
	puel #		Usual Residence of Decedent  10a. Stata  10b. County	10c. 6	City, Town	or Location					1	Od. Insid	la City Limits
	Mary Fed sh	tor	Maryland St. Mary	/'s	Leona	rdtown						10	Yas 2₽No
	th with the 23a or 28	al Director	10e. Street and Number 22803 Pope Street				p Coda 2065(	)	10	U.S.A.		ntry?	
020	d within 72 hours efter deeth with the Maryland jiene. I than "naturat", or Items 23a or 28s-f show than Marifest Examinet must be notified at	i by Funerai	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	I2. Was Decedant Evar In Armed Forces? 1 ☐ Yes 2 ☐ No It Yes, Give Year or Dates:	U,S.	13. Was Dece It Yes, spe 1 \( \subseteq Yes	city Cub	dispanic Origin? (Sp an, Maxican, Puarto Specify:	pecify Yas or No- p Rican, atc.)		e - Amaric ck, Whita, Wh		n,
5-0	72 h	etec	15. Decedent's Educ (Spacify only highast grada	cation complatad)	16a. I	Decedent's Usu (Giva kind of w	al Occup ork dona	pation during most of world)	king	16b. Kind of Bu	isiness/ind	dustry	
121	within lene. than "	Completed	Elementary/Secondary (0-12) 9th Grade	College (1-4or 5+)	1	ito Mecl				Tire	Como	2017	
pt	e filed withing Hygiene. other than	Be Co	17. Father's Name (First, Middle, Last)		אכ	ito neci	MILL		ne (First, Middla, N			arry	
ylar	Mente Mente orked orked ortic ev	To B	James Latham	Mattingly	, Sr.			Hazel	Bear	trice	T	oute	
, Mar	and 2 sho eith end i 27 is me		19a. tntomant's Name/Relationship (Typ. Lydia E. Mattingly					and Number or Ru treet, Le			Stata, Zip 2065		
Baltimore, Maryland 21215-0020	pemilt. Pages 1 end 2 should be filed Department of Heelth and Mentel Hyg Important: if Item 27 Is marked other any Injury or other traumatic event, ance.		20a. Method of Disposition 1 ⊠ Burial 2 □ Cramation 3 □ Re 4 □ Donation 5 □ Other (Spacify)	emoval from State	cematary	Disposition (Na v. cramatory or S Memol	othar pla	Gardens		20c. Location - Leonard			
Balt	Departi Departi Importi any Inj pnce.		21. Signature of Funeral Servica License	Incliner				ess of Facility. Y-Gardine. 270, Leon				2065	60
			23a. Part1. Enter the disease, of complete shock, or heart feilure. List only on	cations that caused the de e ceuse on each line.	ath. Don	ot enter the mo	de of dyir	ng, such as cardiac	or respiratory arre	est,			Between
	Physician /Medical		Immediate Cause (Final	1-1			_				1	Onset a	and Deeth
	Examiner		disease or condition resulting in death) a.	65W		onsequenca of		vicid	•			Cu	it.
	70 #E	Iner		500.0	(01 83 8 0	orisequerioa ori	•						
o,	death certificate be executed e ettending physician end of for use as the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a co	onsequence of)	*	_					
68760,	tificate be ig physici as the bu	Medical	Cause (Disease or injury that Initiated avants resulting in death) Last	Dua to	(or as a co	onsequence of)	:						
Вох		an/N	d.										
	e dea the ett ned fo	Physician/	Part II. Other significant conditions cont	tributing to death but not re	sulting In	the underlying	cause giv	van in Part I.	23b. Did to	bacco use co	ntribute to	the cau	sae of death?
P.0	es thet the death cei igned by the ettendir be detached for use	by Phy							1 □ Ye	2 No	3 Prot	bably	4 Unknown
of Vital Records,	requir been s should	Completed b							24a. Was ar perform		ava	allable pr	osy findings rior to of cause
œ e	The la ate ha page	Com							1 ☐ Ye	s 2 No	10	∃Yes	2 No
/ita	Physician: r this certificated director,	Be	25. Was case reterred to medical examiner?	10.1					th (Chack only one	3)			/
of	Physic this c	۲.	1 Ves 2 No He  27. Manner of Death		□ ER/Out		UA		ome 5 Reside			y)	
CO	h. After funer	tion	1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)		jury	28c. Injui Woi 1 □	rk? Yes 2. ☑/No	28d. Describe ho		ed		
Division	Attending or deeth.	ifica	3 Suicide 6 □ Could not be	28e. Place of Injury - At	homa, fari	m, street, tactor		X	28f. Location (Str	eet and Numb	ar or Rura	l Routa	Number,
ā	s efte	Certification:	4 Homicide	building, etc. (Spec	to m	n 0 1	110	ed	City or Town	, Stata)			
	To the Hospital or Attending Physician: The law within 24 hours effect deeth.  To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one)	ician: To the best of my kr er: On the basis of examinand menner stated.	nowledge,	death occurred	at the tir	me, date and placa,	and due to the ca red at the time, da	use(s) and me ite and placa,	nner as st end due to	tated.	se(s)
	To the Vithiu To the Comp	M	29b. Signature Int titla of certifier	4		29	c. Licens	a number	29	d. Date signe	d (Month,	Day, Yea	ar)
			mys	m from	)		01	4285	-	6:	3 - 4	77.	
			30. Name and address of person who con		em 23e) (1	Type, Print)	T		Mar-7	3 2005	.0		
	Sta	te	William D. Boyd,  31. Dete filed (Wonth, Day, Year)	11, M.D.	nature		reor	nardtown,	Marylan	d 2065	10		
	_ 3la	rc.	1111 11/1 1007	HILL AS ALL	P. I	1 48							



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State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3 Time of Death Day **Physician** Charles Henry Mason, Sr. June 1997 /Medical 12:15 PM 4a. Facility Nama (If not institution, giva street end number) 4b. City. Town, or Location of Death 4c. County of Daath **Examiner** St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foraign **Funeral** 1 M 2 □ F Yrs 225-10-2386 86 Director Usual Rasidance of Dacadent 10a. Stete 10b. County 10c. City, Town or Location 28a-f show 10d. Insida City Limits traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yas 2 ■ No Maryland St. Mary's Tall Timbers 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 23a 18 River Road 20690 United States permit. Pages 1 and 2 should be filed within 72 hours eftar deeth v Department of Health end Mantal Hyglena. Important: If itam 27 is merked other than \*natural; or items 23s any injury or other traumatic event, the Medical Exemples 12. Wes Dacedant Evar in U,S. Armed Forces? 13. Was Decedant of Hispenic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 11. Marital Status 14. Race - Amarican Indian. Fun 1 ☐ Yes 2 No If Yas, Giva Year or Dates: 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 White 1 ☐ Yas 2 ■ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Spacify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Postmaster U.S. Postal Service 17. Fether's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Sumame) Emmett Mason Mary McCormack 2 19b. Mailing Addrass (Straet and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Typa, Print) Charles H. Mason, Jr. 18 River Road, Tall Timbers, Maryland 20690 Son 20b. Place of Disposition (Nama of cematary, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 ■ Burial . 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) St. George Catholic Cemetery 6/6/97 Valley Lee, Maryland 22. Name and Addrass of Facility Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650 Edward N. Brinsfield, Jr. M00052 23a. Part1. Entar tha diseese, or complications that causad the daath. Do not entar tha moda of dylng, such es cardiac or raspiratory errest, shock, or haart failura. List only ona causa on each lina. Approximata Intarval Batween Onsat and Death **Physician** Immediata Cause (Final disaasa or condition resulting in death) AUte NON GWIVEMYOTOR /Medical Examiner Examiner bunel-transit Sequantially list conditions, if any, laading to immadiate causa. Entar Underlying Causa (Disease or injury that Initiated evants resulting in daath) Last Due to (or as a consequence of): physician s the buriel Box 68760, - monon Physician/Medical esn Part II. Other significant conditions contributing to death but not rasulting in the undarlying ceuse givan in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? CONSONE GLOST Failve 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ρ Completed 24b. Wara eutopsy findings Charic Olstveitre primors Dissi 24a. Wes en eu evailable prior to completion of ceuse of death? certificate 1 Tyas 2 TNo 1 ☐ Yas 2 ☐ No of Vital Hospital or Attending Physician: 25. Was cesa referred to medical axaminar? Be 26. Placa of Daeth (Check only ona) Hospital: 1 Yas 2 No Othar: 4 Nursing Home 5 Rasidance 6 Other (Specify) Certification: To 1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Division 5 Pending Invastigation 1 PNatural after death. 1 Yas 2 No 2 Accidant tha 6 Could not be datarmined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Spacify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homlcida To the Hospital within 24 hours a To the Funeral Completely filled 12 Certifying Physician: To tha best of my knowledga, death occurred at tha tima, data end plece, and dua to tha cause(s) and mannar as stated.

[ Medical Examiner: On tha basis of axamination and/or investigation, in my opinion, death occurred at tha time, date and place, and dua to tha causa(s) and manner stated. 29a, Certifian Medical (Check only one) 29b. Signature end titla of certifier 29d. Date signed (Month, Day, Yaar) West D36206 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) KIRAN D. MEHTA, M.D. PO Box 664 LEONARDTOWN, MD 31. Date filad (Month, Day, Year) 32. Registrar's Signatura State Julia Daviden Rardall 6 1997 Registrar

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₹ (€) -24 A CONTRACTOR OF THE REAL PROPERTY.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Yeer WILLIAM HAYDEN MORGAN, JR. 1997 6;18 AM. June 16 /Medical 4a. Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** St. Mary's Hospital Leonardtown St. Mary If Undar 1 Yaar | If Undar 24 Hrs. 8. Deta of Birth (Months Days Hours Min. (Month, Dey, 5. Social Sacurity Number 7. Age (In yrs. lest birthday) Birthplece (Steta or Foreign Country) **Funeral** Days 1 M 2 □ F 215-36-5717 Yrs. Director 62 Nov 1, MD Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 No Director St. Mary Mechanicsville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 40781 Parlett Morgan Rd. 20659 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Orlgin? (Specify Yes or No-It Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 1 ☐ Navar Married 2 ☑ Marriad 1 Yes 2 No If Yes, Give Yaar or Dates: 21215-0020 1 ☐ Yes 2 X No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Peges 1 end 2 should be filed within nent of Health end Mentel Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 8 Farmer Own Farm Baltimore, Maryland 17. Fether's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Be William Hayden Morgan, Sr. Catherine Matilda Hyde ည 19e. Intorment's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2 s Department of Health er Important: If Item 27 la any Injury or other trau once. 40781 Parlett Morgan Rd., Mechanicsville, MD 20659
lece of Disposition (Neme of Date 20c. Location - City or Town, State Dorothy L. Morgan/Wife 20b. Plece of Disposition (Neme of cemetery, cramatory or other place) 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Charles Memorial Gardens 6/19/97 Leonardtown, MD 21. Signature of Funeral Service Licensa 22. Name end Address of Facility.
Mattingley-Gardiner Funeral Home, P.A. ichael Jaroliner P.O. Box 270, Leonardtown, MD 20650 23a. Pert1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, ox heart tailure. List only one cause on each line, Approximete Intervel Between Onset end Deeth Physician Immediate Cause (Finel diseese or condition resulting in death) /Medical Examiner Due to (or es e consequence ot): The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last Due to (or es e consequence ot): Division of Vital Records, P.O. Box 68760, anguene Physician/Medical perpheral rescular descare nenal signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of desth? 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No þ cate has been signed bege 2 should b 24b. Were autopsy findings eveileble prior to completion of cause of daath? Be Completed 24a. Was en eutopsy performed? r this certificate haral director, pege 2010 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yas 2 ☐ No 1 | Impatient 2 ☐ ER/Outpetlent 3 ☐ DOA 28c. Injury et Work? Certification: 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Neturel invastigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, tarm, street, fectory, office building, etc. (Spacify) 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 4 Homicide Medicai 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29b. Signetura and title of certifian 29c. Licansa number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of deeth (flore 23a) (Type, Print) I.DAMALOUJI M.D 650 MOAKLEY ST. LEONARDTOWN, MD. 20650 31. Date tiled (Month, Day, Yeer)
JUN 18 1997 32. Registrer's Signature State

Registrar

DHMH 16 Rev 6/95

WILLIAM HAYDEN MORGAN



HERMAN REISER MARTIN

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible . . .

al Hygiene State of Ma

aryland /	Department of Health and	menta
	Certificate of Death	

If Under 1 Year

**Physician** /Medical **Examiner** 

Herman Reiser Martin 4e. Fecility Neme (If not institution, give street end number)

2. Dete of Deeth Month Dey 23, JUNE

Reg. No.

1997 7:28 PM

604 BRENDA WAY

1. Decedant's Name (First, Middle, Last)

4b. City, Town, or Location of Death FINKSBURG

4c. County of Deeth

CARROLL

10g. Citizen of Whet Country?

**Funeral** Director

28a-f

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items 23a death v

/Medical

Examiner

sician end burial-transit

physician

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signed by the et

should page 2 s Examiner

Physician/Medical

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Completed

Be

Certification: To

edicai

Examiner must be notified at

the Marylend

5. Sociel Security Number 217-12-6693 Usual Residence of Decedent 10a State 10b. County

Deys Months 72 Yrs 10c. City, Town or Location

| If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | July 26 1924

9. Birthplece (State or Foreign Country)
Maryland

show

Director

Funeral

þ

Completed

MD

Carroll

1X M 2□ F

Westminster

10d. Inside City Limits 1 ☐ Yes 2 No

3. Time of Deeth

10e. Street end Number

604 Brenda Way

10f. Zip Code 21157 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.)

United States

1 Never Married 2 Married 3 Widowed 4 □ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 □X/es 2 □ No If Yes, Give Year or Dates: WW ] WWII

1 ☐ Yes 2 No Specify:

 Race - American Indien, Black, White, etc. Specify: white

15. Decedant's Education (Specify only highest grade completed)

7. Age (In yrs. lest birthday)

16a. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT usa ratired)

16b. Kind of Business/Industry

Elemantary/Secondary (0-12)

Collega (1-4or 5+)

office worker

BGE

17. Fether's Neme (First, Middle, Last)

Margaret Reiser

Data

18. Mother's Name (First, Middle, Maiden Surneme)

Francis Augustus Martin 19a. Informent's Name/Retetionship (Type, Print)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)

715 Maiden Choice Lane Apt. CC413 Catonsvill

Imelda M. Kral, sister 20e. Method of Disposition

20b. Place of Disposition (Name of cemetery, cremetory or other place) 6 24 197 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

20c. Location - City or Town, Stata Overlea, Maryland

4 □ Donetion 5 【XOther (Specifientombment Gardens of Faith 21. Signeture of Funeral Service Licensee

22. Nama end Address of Facility

Kathurie Putts - Swetter 412 Washington Rd., Wes 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cardiac or raspiretory arrest, shock, or haart failura. List only one cause on each line.

Pritts Funeral Home & Chapel 412 Washington Rd., Westmins Westminster, MD Approximata Intervel Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in deeth)

a Arteriosclerotic Cardiovascular Disease

Dua to (or as a consequence of)

Sequantially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in daeth) Last

Dua to (or es e consaquence of):

Due to (or es e consequence of):

Part II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth?

INSPECTED NSPECT 1 Yes 2 XX

1 ☐ Yes & QQNo

25. Was case referred to madical examinar? 1√ Yes 2□ No

27. Menner of Death

1 Naturel 2 Accident

3 Suicide

4 Homicida

Hospitel: 5 Pending investigation

6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28b. Tima of

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred

29a Certifian 1 Certifying Phyeician: To the bast of my knowladga, deeth occurred et the tima, data and plece, end due to tha cause(s) and menner es steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and many of stated.

26. Placa of Death (Check only ona)

29c. License number O.C.M.E. 29d. Date signed (Month, Dey, Year) JUNE24, 1997

28f. Location (Straat and Number or Rural Routa Number, City or Town, State)

30. Name end eddrass of person who complated causa of daath (Item 23e) (Type, Print)

FOWLER M.D. 111 Penn Street, Baltimore, Maryland 21201 DAVID R.

JUN 26 State

29b. Signature end titla of certifier

32 Aggistrar's Signeture

**DHMH 16 Rev 6/95** 

permit. Pages 1 end 2 should be filed within 72 hours effer c. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural". ce is any injury or other traumatic events. **Physician** 

The law requires that the death certificete be executed P.O. Box 68760, Records. Division of Vital spital or Attending Physician: Thours after deeth.
neral Director: After this certificate y filled in by the funeral director, pt

Registrar

within 24 hours at To the Funeral D completely filled I Hospital

ţ

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dete of Deeth 3. Tima of Death McEachern Florence M. **Physician** Month Year June 28, 1997 11:15AM /Medical 4a. Fecility Nema (If not institution, give street end number) 4b. City, Town, or Location of Daeth 4c. County of Death Examiner Clinton Prince George's Southern Maryland Hospital 5. Sociel Sacurity Number If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. lest birthday) **Funeral**  Birthplace (State or Foreign Country) Days 1 □ M 2 X F 86 Yrs. 032-14-9954 Director MA June 2,1911 Usual Rasidance of Dacedant the Meryland 10a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 28a-f ehow traumatic event, the Medical Examiner must be notified at Maryland Prince George's Clinton 1 ☐ Yes 2 XNo Director 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? ö 20735 U.S.A. 8914 Ballard Lane "naturel", or Items 23a deeth Funeral 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yas, Giva Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Rece - American Indien, Black, Whita, etc. 11. Maritel Status filed within 72 hours eftar Hyglene. 1 ☐ Never Merried 2 ☐ Marriad Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ White 3℃ Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a, Decedant's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working lifa. DO NOT usa ratired) permit. Pages 1 end 2 should be filed within Department of Health end Mantal Hyglene. Important: if flem 27 is merked other than eny injury or other trainment. Elamantary/Secondary (0-12) Collaga (1-4or 5+) Administrative Supervisor State Government 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Julia Dean John J. Scanlon 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 8914 Ballard Lane Clinton, Maryland 20735 Dorothy C. Hearon (Sister) 20b. Placa of Disposition (Name of camatery, crematory or other plece) 20a. Mathod of Disposition July 129 20c. Location - City or Town, Stete 1 DBurial 2 Crametion 3 Ramovel from State Trinity Memorial Gardens 1997 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lee Funeral Home, Inc. 22. Nama and Addrass of Fecility 6633 Old Alexandria Ferry Rd Clinton Maryland 20735 Part1. Enter the diseesa, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** /Medical Immediata Causa (Final diseese or condition rasulting In daath) Examiner VFECTION The law requires that the deeth certificata be executed the buriel-transit Sequantially list conditions, if any, leading to immadiata cause. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting In death) Last and Division of Vital Records, P.O. Box 68760. attending physician for use as the burie Physician/Medical Due to (or es e consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably Wunknown þ 2 R DISFASE 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? Completed peen complation of causa of death? has 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: After this certifica completely filled in by the funeral director; t Be 25. Was casa rafarred to medical axaminer? 26. Place of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 Yas 2 No Medical Certification: To 1 Unpatient 2 ER/Outpatiant 3 DOA 28a. Data of Injury (Month, Dey Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 5 Panding Invastigation 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 Sulcide 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homleide 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Cartifia: 29b. Signatura and title of certifie 29c. Licansa number 29d. Dete signed (Month, Dey, Year) d causa of daath (Itam 23a) (Type, Print)

32. Registrar's Signature

State Registrar 31. Data filed (Month, Day, Year)

JUL 0

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 7 2 1 0 7 7

Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Date of Death 3. Time of Death Month **Physician** 11: 45 Morrell MARY 1 21 /Medical JOH 4a. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2□X Months Deys Yrs. Director 162-30-5291 60 APRIL 11, 37 SOUTH CAROLINA Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No Director N/A N/A WASHINGTON, D.C. 10e. Street end Number 10f. Zip Code 10g. Citizen of Whef Country? 1435 NEWTON ST. N.W. 20010 UNITED STATES AMERICA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: BLACK p Specify: 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highest grede completed) 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry illed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th GRADE SALES PRIVATE permit. Pages 1 and 2 should be filed.
Department of Heelth and Mental Hygic important: If Item 27 Is marked other I any Injury or other traumatic avent. 17 Fether's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES LITTLES MAMMIE BYRD 0 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1435 NEWTON ST. N.W. GEORGE H. MORRELL, JR. W.D.C. 20010 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removel from State HARMONY MEM. PK. 6-27-97 4 ☐ Donetion 5 ☐ Other (Specify) LANDOVER, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility JOHNSON & JENKINS INC. 716 KENNEDY ST. N.W. W.D.C. that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, Approximate Intervel Between Onset end Death **Physician** /Medical Immediete Ceuse (Final System Sarcordosis Nervous diseese or condition resulting in deeth) Examiner Due to (or as e consequence of) Examiner eas burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in deeth) Lest and Due to (or es e consequence of): P.O. Box 68760. physician The law requires that the death certificate be Physician/Medical the Due to (or es e consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? page 2 should 24a. Wes en eutopsy performed? Completed peen certificate has 1 ☐ Yes 2P No 2 200 1 ☐ Yes Division of Vital the Hospital or Attending Physician: nin 24 hours efter death. Be 25. Was case referred to medical 26. Piece of Death (Check only one) exeminer Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 es 2 No After this 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending investigation efter death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be in by t 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 | Homicide within 24 hours eft To the Funerel DI completely filled in 29a. Certifier Certifying Phyelcian: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) end menner es steted. 2) redical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) end manner stated. 29b. Signature end fitte of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 8218 W is consin ber July Day Begistra & Sic laws State Registrar

Santa mi

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State of Maryland / Department of Health and Mental Hygiene 9 / 2 | 0 7 8

_						Certificate of	Death		Reg. No.	-	1070
	Physic /Medi		1. Decedent's Name (First, Middle, Las	,	MINN.	ick		2. Dete of Do Month JUNE	Day 23 /	Yeer 997	3. Time of Deeth 4:20 PM
	Exami		4e. Fecility Name (If not institution, give WASHINGTON ADVE		PITAL		Takon	or Location of Dee		of Deeth	·v
	Funeral Director		5. Social Security Number 6. Sr 578-42-8409  Usuel Residence of Decedent	ex 7. Age	64 (In yrs. last birt	thday) If Under 1 Year Months Deys	If Under 24 h	fin. 8. Dete of Bi (Month, Do	rth av. Year)	9. Birthple Counti	ece (State or Foreign ry) ield, S.C.
	Maryland f show	ō	10e. State 10b. County		10c. City, Town					10	od. Inside City Limits
	28a	Director	District of Col	umbia	wa	shington 10f. Zip Code			10g. Citizen of	What County	
	h with		1207 D Street,	N. E.		200	002			ed St	
020	72 hours after death with the Maryland naturel', or items 23a or 28a-f show after Exercities must be notified at	by Funeral	11. Marital Stetus  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent B Armed Forces? 1 A Yes 2 N If Yes, Give Year or Dates:	io 2/6/53	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? en, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	o- 14. Rac	ca - Americe ck, White, e	n Indien, tc.
Maryland 21215-0020	d within 72 hours Jiena. r than "natural", The Medical Exe	Completed I	15. Decedent's Ed (Specify only highest grad Elementery/Secondary (0-12)	ucation	16e.	Decedent's Usuel Occup (Give kind of work done life. DO NOT use retire	during most of i	working	16b. Kind of B		
121	Hygien other th		12			Hospital			Priva		
anc	a a b >	Be	17. Father's Name (First, Middle, Last)	-1-				Neme (First, Middle		ne)	
Z	d 2 should be th and Menta 7 is marked traumatic ev	ဥ	Vannie Minni  19e. tnformant's Neme/Relationship (7		105	Mailing Address /Street		ucy Butle		Ctata 7in /	Ondo
Ma	D = 1 = 0		Lucy Minnick - M			Mailing Address (Street 07 D Street					0002
ore,	of Health Item 27		20e. Method of Disposition		20b. Plece of	Disposition (Name of		Dete	20c. Locetion -		
imo	Page net c int: If iry or		1X Burial 2 ☐ Cremetion 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify		1	. Creek Ceme	.,	6/27/97	Washin	aton	D C
Baltimore,	permit. Pages 1 en Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service License	to +	711	22. Name end Addre STEWART E	ess of Fecility	HOME, In	с.		
			23a 1rt1. Enter the disease, or comp hock, or heert feilure. List only of	licetions that caused	the deeth. Do n	4001 Benr ot enter the mode of dyi	ning Roa	d, N.E.,	Washingt prest		. C . Approximate Intervel Between
	/Medical be assented of physician and os the burlet-transit	edicai Examiner	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events	b	Due to (or es e co	onsequence of):	endioi	vas cular	Disea	33-2	years
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Division of Vital Records,	S S S	Completed b	Carcinoma	Lary	n/			24e. Wes	en eutopsy ormed?	com	e eutopsy findings leble prior to pletion of ceuse eeth?
a F	ician: The lav certificate has rector, pege 2							10	Yes 2 No	10	Yes 2□ No
<u> </u>	sician certifi irector	9 Be	25. Was case referred to medical exeminer?	Hospital:	-X	nations 3 DOA Oth		eeth (Check only			
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io	death. ctor: After y the funar	atio	1 Meturel 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day			k? Yes 2 □ No				
Divis	or Att	Certification:	3 Suicide 6 Could not be determined		ry - At home, fare	m, street, factory, office		28f. Location ( City or To	Street and Numb wn, State)	er or Rural I	Route Number,
	the Hospital or Ai in 24 hours aftar of the Funeral Direct indetely filled in by	edical	one)	sician: To the best of ner: On the basis of e end menner state	examinetion end	deeth occurred et the tir for Investigetion, In my o	pinion, deeth oc	ce, end due to the curred et the time,	ceuse(s) end me date end place, o	enner as stet end due to th	led. he ceuse(s)
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	TVA Sta	te	30. Name end eddress of person who con the filed (Month, Day, Year)  11. Dete filed (Month, Day, Year)	mpleted cause of decompleted c	420	ype, Print	SBURY	2 Rd H4	attsvil	le Me	2020

AGEITTE STITIPA

Lucy Minnick - Mother

X

1207 D Street, N. E., Washington, D. C. 20002

Rock Creek Cemetery 6/27/97 Washington, D. C.

STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, D. C.

William Commencer Commencer

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

					State	of Mai	ryland /		irtment of l tificate of		ind M		giene 9	2	10	19
	Dhusial		1. Decedent's Name (First,	Middle, L	ast)							2. Date of De	eth	Vasa	3. Tin	ne of Death
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į.	Examir	ner	4a. Fecility Neme (If not inst									ocation of Deat	h 4c. Count	y of Deeth		
	5 4	Ш	14510 Homecr			-			K Hadas 1 Vasa	Silve:		-		gomery		
	<ul><li>Funeral Director</li></ul>		5. Social Security Number 577-20-0111  Usuel Residence of Decede		Sex 1□M 2∏F		(In yrs. lest b	Yrs.	Months Deys		Min.	(Month, De	th 9 <i>y, Year)</i> 21 <b>,</b> 1921	9. Birthp Coun Washi	lece (St try) .ngt	ate or Foreign
	and man		10a. State 10b. Co			1	10c. City, Tox	wn or Loc	cation					1	Od. Insid	de City Limits
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	23a	ral	14510 Homecr	est :	Road #	1016			2	20906			U.	S.A.		
020	filed within 72 hours efter death with the Maryland Hygiene. Ither than "natural", or itame 23a or 28a-1 show ent, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ 3 ☐ Widowed 4 ☐ Div		12. Wes Dec Armed F 1  Yes If Yes, G Year or I	orces? 2 X No ive	er In U,S.		Vas Decedent of l Yes, specify Cub ☐ Yes 2 ☑ No		jin? (Spo , Puerto	ecify Yes or No Rican, etc.)	- 14. Ra Bla Specia	ce - Americ ck, White, o		
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Baitimore,	permit. Peges Department of Important: If It eny injury or once.		21. Signature of Funeral Se	Lice	nsee	101		22. Fr	Name end Addre	ess of Fecility	Son	ıs Funer	cal Home	, P.A	۱.	
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5	Physician: r this certific ral director,	၉	1 ☐ Yes 2 No			Inpatient	2 ☐ ER/O	utpetient		4 LI NUR	sing Hor	me 5 Resid	dence 6 □Oth	er (Specify	)	
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5	s afte	Cert	4 ☐ HomicIde		buildi	ing, etc. (	Specify)					City or Tow	vn, Stete)			
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	(3)	-	30. Neme end eddress of per	son who	completed caus	e of deet	h (item 23e)	(Type, Pr	rint)				June 19	, 199	/	
			Michael S. So	chino					kwood Dr	ive #2	200,	Silver	Spring	, MD	2090	01
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			JUN 60	100	17		12.5									

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THE PLANE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 7 2 1 0 8 0

						Cer	tificat	e of	Death			Reg. No.		
	Dhusis	·	1. Decedent's Name (First, Middle,	Last)					,		2. Date of D Month		Year	3. Time of Death
	Physic /Medi		Paul	Marion	ni						JUNI	E 19.	1997	20:52 pr
	Exami		4a. Fecility Name (If not institution,					. 7	4b. City, To	wn, or Lo	ocation of Dee		ty of Death	
			University	of Mar	yland	1 H	rigizo	raf	B	alti	more	Balt	imore	City
	Funeral		5. Sociel Security Number		Age (In yrs. last	t birthday)	If Under	1 Year Deys	If Under		8. Date of B			lace (State or Foreign
	Director	L	173-38-1216	1₩ 2□F	49	Yrs.	MONITS	Deys	Hours	Min.	8. Date of B (Month, D June 2)	7, 1947	Penn	sylvania
	pr ,		Usual Residence of Decedent											
	h tha Maryland r 28a-f show	-	10a. State 10b. County	_	10c. City, T	own or Lo	cation						1	0d. Inside City Limits
	Ba-f	ç	Maryland Prince	George's	Greer	nbelt								1 X Yes 2 □ No
	ith th	Dire	10e. Street end Number				10f. Zip	Code				10g. Citizen o	Whet Coun	ntry?
	23a	a	4-G Ridge Road				207	770				U.S.A.		
	72 hours after death with the Maryland natural', or items 23e or 28e-f show picel Examiner must be notitled at	Funeral Director	11. Marital Status	12. Was Deceder Armed Forces		13. V	Vas Dece	dent of F	lispenic Ori en, Mexicar	igin? (Spi	ecify Yes or N Rican, etc.)		ca - Americ ack, White,	
20	or it	Y F	1 Never Married 2 Marrie	d 1 ☐ Yes 2 ☒ If Yes, Give	] No		Yes					Spec		nite
5-0020	ira!	d by	3 ☐ Widowed 4 ☐ Divorced	Yeer or Detes								Opos	W.I.	irre
5	"natural",	Completed	15. Decedent's (Specify only highest	Education grade completed)	1	6e. Deced (Give	ent's Usu kind of wo	el Occup rk done	pation during mos d)	t of work	ing	16b. Kind of	Business/Inc	dustry
2121	within and.	gm	Elementary/Secondary (0-12)	College (1-4o								MAGA		
7	tygie her nt.	ပိ	17. Father's Name (First, Middle, L.	5+	<i>P</i>	Astro	pnysi	cls		ada Alam	o (Films & Adiabatt	NASA a, Maiden Suma		
an	ntaf h	Be	Samuel Salvatore								M. Coco		me)	
2	2 should be filed within and Manial Hygiana. Is marked other than raumatic event, the Manial	2												
Maryland	12 sl h and la n		19a. Informent's Neme/Relationshi									ber, City or Tow		
	l and laalt		Joan T. Marionni 20e. Method of Disposition	- Wife		+-GR a of Dispos			d, Gr	eenbe		ryland		
Baltimore,	pemit. Pages 1 and 2 should be filed with Department of Health and Mantal Hyglane Important: if Item 27 is marked other tha any Injury or other traumatic event, the ONGS.		1 ☐ Burial 2 ☐ Cremetion	B □Removal from State		etery, crem	netory or o	ther pla	ce)	1	Dete	20c. Location	- City or To	wn, State
ţ	tman tant:		4 ☐ Donetion 5 ☐ Other (Spe		Metr	opoli	ltan	Crem	natory	06	/22/97	Alexan	dria,	Virginia
Bal	Depar Depar Impor any in		21. Signeture of Funeral Service Li	censee	4	22 F	. Name er	Addre	asch	y S Soi	ns Fune	eral Hon	ne. P.	Α.
NA.	4D = 4 0		laudet	te d. &	Sach							attsvil		
-			23a. Pert1. Enter the disease, or c shock, or heart failure. List o	omplications that cause	ed the death. I									Approximate Intervel Between
	Physician			_										Onset end Deeth
и	/Medical		Immediete Cause (Final diseese or condition	56	Epsis	4								ne week
	Examiner		resulting in death)	θ	Due to (or es		uence of):							
	p #	ine		<b>-</b> b									i	
	aath certificata ba axecuted attanding physician and for usa as the burial-transit	Examiner	Sequentially list conditions,	0.	Due to (or es	a consequ	uence of):				_			
30,	oa axa Sian a	E I	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury										1	
68760,	ertificata ba axecut Jing physician and sa as the burial-trar	Medical	that initiated events resulting in death) Lest	C	Due to (or es	e consequ	uenca of):						1	
9 x	ing p	Me											- !	
Box	ath of ttand or us	lan		<b>d</b> .										
0	requiras that tha daath o seen signed by the attand should be datached for us	Physician	Part II. Other significant condition	s contributing to death	but not resultin	g in the un	derlying o	euse giv	en in Pert I		23b. Did	tobecco use c	ontribute to	the cause of death?
Ρ.	d by	Ph									1□	Yes 2 No	3 Prot	pably 4 Unknown
Ś	as tha igned be dat	by												
Records,	v requira been sig	Completed									24e. Wes	s an eutopsy ormed?	ave	ere eutopsy findings eilable prior to
ec	Na S	pie											of c	mpletion of cause deeth?
<u> </u>	W T 00	100									1 24	Yes 2□No	10	Yes 2 No
Vital	iclan: The certificata rector, pag	Be (	25. Wes case referred to medical examiner?						26. Plece	of Deeti	h (Check only	one)		
of V		2	1 ☐ Yes 2 X No	Hospital:	tient 2 ER	/Outpetient	3□ D0	Oth	ier: 4□ Nu	ırsing Ho	me 5□Res	idence 6 🗆 O	ther (Specify	()
0	Attending Phiar death. ector: Aftar thiby the funeral		27. Manner of Deeth	28e. Dete of In (Month, D	jury 28	b. Time of Injury	2	8c. Injur Wor				how injury occu		
Division	Attending or death. Sector: Aftai by the fune	atic	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	ay / oai/	прогу	M:		Yes 2□	No				
<u>Vis</u>	ar da ecto by th	tific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 200. Place of It	njury - At home	, ferm, stre	et, factory	, offica				(Street end Nun	ber or Rura	l Route Number,
Ö	s aftar s aftar s Direct	Certification:		building, e	nc. (Opecity)						Ony or 10	Win, Stelley		
	To the Hospital or Attend within 24 hours aftar daati To the Funeral Director: complately filled in by tha		29a. Certifier (Check only 2 Medical F	Physician: To the bes	t of my knowled	dge, death	occurred	et the tir	ne, date en	d place,	and due to the	cause(s) end n	nenner es st	eted.
,	in 24 he Fu he Fu platel	edical	one)	caminer: On the basis end manner s	teted.	ena/or inv	estigation	, in my o	pinion, dea	th occurr	ed et the time,	, date and place	, end due to	the cause(s)
,	To the within To the comple	Σ	29b. Signature and title of certifier				290		e number	47		29d. Date sign		
	(		30. Name end gardress of person who completed cause of deeth (Item 23e) (Type, Print)							19	,1997			
	(10)			no completed cause of	deeth (Item 23	e) (Type, f	Print)							
			JANAKI K	uruppu	deeth (Item 23 2 2 trar's Signature	- S.	GR	EEN	E S	7	BAUTIN	MORE		
	Sta	ite	31. Date filed (Month, Day, Year)	32 Regis	trar's Signature					/				
	Registi	ar	JUN 23 1	197 Jahr	Musker	Karolal								

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State of Maryland / Department of Health and Mental Hygiene 1 2 1 0 8 1

				State of Mary	-	ertificate of		мена пу	Reg. No.	60	001
	Physic	ian	1. Decedent's Name (First, Middle, Last	4	.0.16			2. Dete of De Month	eeth Dey	Yeer	3. Time of Death
	/Medi	cal	4a. Facility Neme (If not institution, give	MATT +	1EWS		4b. City, Town, or	JUNE Location of Deat	20   90 h 4c. County		06.20 PM
7	Exami	ner	Prince George's	Hospit	a/	1	Cheren			-	Lispras
	Funeral Director	Г	5. Social Sacurity Number 6. Se 241 6 9 7338	M 2DF 7. Age (In	yrs. last birthday O Yrs.	If Under 1 Yaa   Months   Days	r If Under 24 Hrs	8. Date of Bir	th ay, Year) 1936		laca (State or Foreign try)
	be filed within 72 hours efter death with the Maryland tal Hygiena dother than "natural", or flems 23e or 28e-1 show event, the Medical Exerciper Laut be notified at	ctor	Usual Residence of Decedent  10a. State  10b. County  Prince (	_	ent Pl	ocation easest				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28	Direc	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	itry?
	s 23e	era	6815 HASTIN				743		us	4	
020	urs efter death with the Maryla al', or Nems 23e or 28a-f sho Exacinerun be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorcad	12. Wes Decedent Ever Armed Forces?  1  Yas 2 No If Yes, Give Yaar or Dates:	in U,S. 13.	Was Decedent of If Yes, specify Cul	Hispenic Origin? (S ben, Mexican, Puert Specify:	pecify Yes or No to Rican, etc.)	Specify	ce - Americ ck, White,	an Indian, atc.
2-0	72 hours "natural", edical Ex	eted	15. Decadent's Edu (Specify only highest gred	cation	16a. Deca	ident's Usuel Occu	petion during most of wor	rking	16b. Kind of B		
121215-0020	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiena. Important: If item 27 is markad other than "natur any injury or other traumatic evant, the Medical once.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retin	River		Se14-		loyed
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	ith and 2 st is n 27 is n		19e. Informent's Name/Relationship (Tymil ford P. mat	10.4.16	19b. Mail		84. New			_	Code)
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Ē	Page ment ant: If ury or		1 ☐ Burial 2 ☐ Cremetion 3 🕻 F 4 ☐ Donetion 5 ☐ Other (Specify)	enioval ironi state	dillscre		0 .	24	Clinto	4,4	10
Baltimore,	permit. Pages 1 end 3 Department of Health Important: If item 27 i any injury or other tr. 2000.		21. Signature of Funaral Servica Licanso								
1			23a. Part1. Enter the disaase, or complishock, or heart feilure. List only or	cations that caused the cae ceuse on each line.	death. Do not en	ter the mode of dy	ing, such es cardiac	or respiretory e	rrest,		Approximata Interval Between
	Physician /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	Resp	irato	y fai	due				Onset and Death Sudden
	اداخا	Jer		Dife	to (or es e conse	quehca of):				1	Suddo.
	secuted end il-transit	amir	Sequentially list conditions,	Due t	to (or es e conse	quenca of):					survey
60,	ate be executed obysician end the buriel-transit	edical Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Dehyd	ration						Days
68760,	Se Se	-	resulting In death) Last  Dua to (or es e consequence of):								
Box	eath certif ettending for use e	Physician/N		1	-1 -01-	3000,	071-50				Months
0	thet the de ed by the e detached i	ysic	Pert II. Other significant conditions con		_	ınderlying cause g	iven in Pert I.				the cause of death?
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Vita	ician: certific rector,	Be	25. Was case referred to medical examiner?	ospitel: 📈		0:	26. Place of Dee				
to o	Attending Physician: or death. sctor: After this certifics by the funeral director, i	. To	1 ☐ Yes 2 No 27. Magner of Deeth	28e. Dete of Injury (Month, Dey Yee		II 3LI DOA	4 LI Nursing H	ome 5 ☐ Resident	dence 6 Oth		)
ion	ath. vr. Afte	atio	Naturel 5 Panding  Z Accident investigation	(Month, Dey Yee	r) Injury		ork? ]Yes 2 □ No				
Divis	s after de	Certific	3 Suicida 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, st ecify)	reet, factory, office		28f. Location (: City or Tox	Straet and Numb vn, Stete)	er or Rura	Routa Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th complately filled in by the funeral	Medical Certification:	29a. Certifier (Check only one) 1 Certifying Phys	Ician: To the best of my ler: On the basis of axam end manner stated.	knowledge, deet ninetion end/or in	h occurred at the ti vestigation, in my	me, dete end placa opinion, daath occu	, end due to the rrad et the time,	cause(s) end ma deta end place,	inner as st end due to	ated. the cause(s)
	Vith To t	Σ	29b. Signature end tille of certifier			29c. Licen	se number		29d. Date signed	d (Month, L	Dey, Yeer)
			Muypa	My		)-	52-332		05	24	997
1	1)		30. Name end eddress of person who co			Α.	9 44 - 2 -	514	-VER	SPR	MA
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State of Maryland / Department of Health and Mental Hygiene Amended # 8. & 9. P.G.C. 6-25-97 cr Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Deeth Month **Physician** GROVER MILLER SR. 10:28PM 17 JUNE 1997 /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner CHEVERLY PRINCE GERREES HUSPITAL CENTER PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign Country) Raleigh 5/6/22 North Carol 6. Sex 7. Age (In yrs. lest birthday). **Funeral** X□M 2□F 577-24-2559 Director June 6, 1922 Usual Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at X□ Yes 2□ No BLADENSBURG Director PG MD 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pegas 1 and 2 should be filed within 72 hours aftar daath with Dapenment of Haelith and Mental Hygiana. I important: If Itam 27 is marked other then "natural", or items 23a or any injury or other traumatic event, the Medical Example of the page. USA 20710 5802 ANNAPOLIS ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. 14. Raca - American Indien. 11. Marital Status Bleck, White, etc. tylyYes 2 No fryes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK by 3 XWidowed 4 ☐ Divorced Year 6 Pres 43-1/20/46 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working life. DO NOT use retired)
FED GOVT (SEC) Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry FEDERAL GOVERNMENT Elementary/Secondary (0-12) College (1-4or 5+) 12 YEARS 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be MARGARET POWELL ROSCOE C. MILLER 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)
729 FAIRMONT ST NW, DC 20010 6 GROVER C. MILLER, JR. (SON) cametery crematory or other place LINCOLN MEMORIAL CEMETERY 6/23/97 20b Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, Stete SUITLAND MD. Burial 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licansee 22. Name end Address of Fecility JOHN T. RHINES CO., INC. 3030 12TH ST NE, DC 20017 ort1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, hock, or heart failure. List only one ceuse on eech line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Final · ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Examiner Due to (or es e consequenca of): Examiner physician and s the burial-transit The law requires that the death cartificeta be axecuted Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Lest Due to (or es e consequença of): Box 68760. Physician/Medical Due to (or es e consequenca of): P.O. I been signed by the a should be dateched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Records, þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? paga 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Certification: To 2 ER/Outpetient After this 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending hours after daath. 1 Tes 2 No investigation 2 Accident To the Hospital or Atter within 24 hours after das To the Funeral Director complataly filled in by th 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 - Homicide 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner es steted. Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner. (Check only one) 29c. License number
PEPUTY IMBU CAL EXAMINE 29b. Signature and title of certifie 29d. Dete signed (Month, Dey, Year) D 33954 30. Name end eddress of person who completed cause of death/(Item 23a) (Type, Print)

State Registrar MARLO

31. Date filed (Month, Day, Year)

JUN 25 1997

HOSPITAL DRIVE, Registrer's Signeture

3001

GOLLE JR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21083

Physician					Certificate	or Death		Reg. No.	•		
		Name (First, Middle, L	Lest)				2. Dete of Month	Death Day	v Y	3. 7 eer	ime of Deeth
/Medical	Kobe		TAGE GE	no			June	24,	1997		55 p.m
Examiner			rive street end number)			4b. City, Town	, or Location of De	eath 4c.	County of		
	5522	Hill Way				Camp Sp	rings	Pr	ince	George	's
uneral Pirector	5. Social Secu 577-62	-5069	4DAM 0DE	6 (In yrs. lest birth 50 Yr	Months	Yaar If Under 24		Birth Dey, Yeer) 8, 19	9 46 Wa		State or Foreig
<b>3</b>	10a. State	ce of Decedent 10b. County		10c. City, Town	or Location					1404 100	in on the
be notified at			e George's		Springs						Side City Limits
or 2	10e. Street en	3 Number			10f. Zip C	Code		10g. Citi	zen of Whe	et Country?	
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Tis marked other than "natural", or items 23s or 28s-f shot traumatic event, the Medical Examinat must be notified at traumatic event, the Medical Examinat must be notified at To Be Completed by Funeral Director	3 ☐ Widow	tus Married 2∰ Married red 4 □ Divorced	12. Was Decedent E Armed Forces? 1 XYas 2 N If Yes, Give Yaar or Detes:	ver in U,S. 1965–68	13. Was Decede If Yes, specif 1 ☐ Yes 2[	ont of Hispanic Origin by Cuban, Maxican, F □XNo <i>Specify:</i>	? (Spacify Yes or Puarto Rican, etc.)		14. Raca - Black, Specify:W	American Ind White, etc. hite	lien,
nt the Madical it. The Madical is	Elementery	15. Decedent's I Specify only highest g Secondary (0-12)	Education rede completed) College (1-4or 5-	+)		done during most of retired)				ness/industry	
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is marked other traumatic event, in	17. Fether's No	eme (First, Middle, Las					Name (First, Mide		-		
15 Bits	Josep	h Francis	Martino			Con	stance C	annat	a		
anne.	19e. Informan	's Name/Reletionship	(Type, Print)	19b. N	deiling Address (	Street end Number o	r Rurel Route Nu	nbar, City o	r Town, Sta	ate, Zip Code,	)
OI b	Mary A	nn Martino	/Wife	552	2 Hill W	lay, Camp	Springs.	Md.	20746		
int: If item 2	20a. Method of	Disposition		20b. Place of D	Disposition (Name cremetory or oth	e of	Date			y or Town, St	ate
2 2		2	Removal from State			onal Cem.	6/27/07	Am 1 3.	natan	Vino	inia
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important: I any Injury o once.	1	1.10	V.11		George	e P. Kalas	Funeral	Home			
	1101	, Mar									
	shock, or	heart feilure. List only	mplications that causad y one ceuse on eech lin	ne death. Do noi e.	t enter the mode	of dying, such es car	rdiac or respiretor	errest,		Interv	oximete el Between
ician dical	Immediate Co	use /Final								Unse	t and Death
niner	Immediete Ce diseese or cor resulting in de	dition	· CUETAS	PATIC	CONO	CAWCE	8			4	IRS
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€ 5	resulting in dea	ith) Lest		oua to (or as a cor	isaquenca or):					1	
2 0	resulting in death) Lest										
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for use											
for use	Part II. Other e	gnificant conditions	d	not resulting in th	ne underlying cau	use given in Part I.	23b. D	d tobacco	uee contri	bute to the c	auee of death
for use	Part II. Other si	gnificant conditions		not resulting in th	ne underlying cau	use given in Part I.					
be deteched for use	Part II. Other s	gnificant conditions		not resulting in the	he underlying cau	use given in Part I.			□ No 3[	☐ Probably	4 Unknow
by Physician/	Part II. Other s	gnificant conditions		not resulting in the	he underlying cau	use given in Part I.	1 24a. W		□ No 3[	Probably  4b. Were eut	4 Unknow
be deteched for use	Part II. Other s	gnificant conditions		not resulting in the	he underlying cau	use given in Part I.	1 24a. W	Yes 2	□ No 3[	Probably  4b. Were eut	4 Unknow
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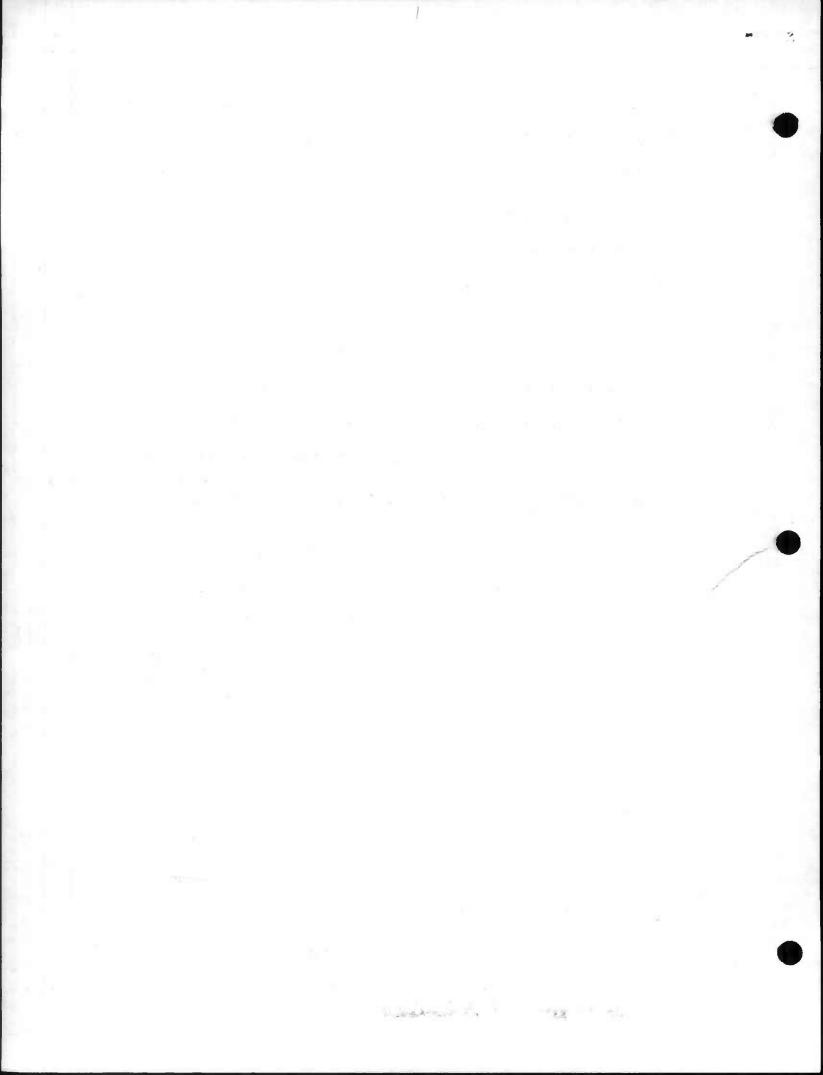
DHMH 16 Rev 6/95

E Proces Section .

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Physician /Medical	Decedant's Nama (First, Middla, Last)     VICTOR     MEI	LLEN	2. Data of Month JUNE	Day Yaar	3. Time of 5 th		
Examiner	4a. Facility Nama (If not institution, giva straat and number) HEARTLAND OF HYATTSVILLE		b. City, Town, or Location of De HYATTSVILLE	eath 4c. County of Death PRINCE GEORG	GES		
uneral frector	15th 2015	to last birthday)  Yrs.  If Undar 1 Yaar  Months Days	Hours Min. 8. Data of (Month, NOV • 1	Birth Day, Yaar) 9. Birthplac Country, WASH,	e (Stata or Foraign DC		
a-f show		FORESTVILLE		10d.	Insida City Limits 1 Yas 2 □ No		
23a or 28a-1 s ust be notthed	10e. Street and Number 3305 PINEVALE AVE.	10f. Zip Coda 207	47	10g. Citizan of What Country USA	?		
Examiner rough by notified at Examiner rough by Funeral Director	11. Marital Status  1 ⚠ Mavar Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Dacedant Evar in Armed Forcas?  1 ☐ Yas 2 ☐ X Y Y Yas, Giva Yaar or Datas:	U,S. 13. Was Decedant of His If Yas, specify Cubar	spanic Origin? (Spacify Yas or n, Maxican, Puarto Rican, atc.) Specify:				
marked other than natural, matic event, the Medical Ex.  To Be Completed by	15. Decedant's Education (Specify only highast grada complated)  Elamantary/Secondary (0-12)  Collega (1-4or 5+)  12th	16a. Decedant's Usual Occupa (Giva kind of work dona d lifa. DO NOT usa ratired)	furing most of working )	16b. Kind of Businass/Indus	try		
B S	17. Fathar's Nama (First, Middle, Last)  EDWIN MELLEN		18. Mothar's Nama (First, Middla, Maidan Surnama)  THURIDOR UNKNOWN  ng Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Code				
other trau	1 Burial 2 Micramation 3 Ramoval from State	19b. Mailing Addrass (Street a 3305 PINEVAL) Place of Disposition (Nama of camatary, cramatory or other place TROPOLITAN CREM	E AVE. FOREST	VILLE, MD 2074 20c. Location - City or Town	17 , Stata		
Important: If it any injury or once.	21. Signature of Funaral Sarvice Licansaa	22. Nama and Addras	e of Encility	LL'S FUNERAL HO			
ng physician and es es the buriel-trensit angles and leadlest tensit and leadlest tensit and leadlest tensit and leadlest tensity and l	Sequantially list conditions, if any, laading to immadiate causa. Entar Underlying Causa (Disaasa or Injury	(or as a consequence of):  Or as a consequence of):	TORY FA LOSED HTZ  ORDER 2	AT INTURY	proximata larval Batween nsat and Death		
been signed by the ettending pr should be detached for use as it leted by Physician/Med	Part II. Other algnificant conditions contributing to death but not ra	sulting In tha undarlying causa giva	in in Part I.	id tobacco use contribute to th			
m P			Þé	erformed? availa comp of das	autopsy findings bla prior to lation of causa th?		
uneral director	27. Mannar of Daath 1√2 Natural 5 ☐ Panding (Month, Day Year)	☐ ER/Outpatient 3☐ DOA Otha  28b. Tima of Injury Work	26. Placa of Daath (Check on ar. 4 Nursing Homa 5 R. at 28d. Dascril	□ Yas 2√□ No □ 1□ Y  ily ona)  asidance 6□ Othar (Specify) be how injury occurred N/A□ Traveling	A		
led in by the Certifical	4 Homicida building, atc. (Space	noma, farm, straat, factory, office ify)  N/A  Street	City or	and struck by n (Straat and Numbar or Rural Ri Town, Stata) Forestyi N/A nd Marib. Pumphrey	auto <sup>outa Numbar,</sup> lle Maryla Pike & Dr.		
ompletely fil	29a. Cartifiar (Check only one)  1 ☐ Certifying Phyaiclan: To tha bast of my kn (2 ☐ Medical Examinar: On tha basts of axamin mannar statad.	owladga, daath occurred at the time attended and/or invastigation, in my op	inion, daath occurred at tha tin	na causa(s) and maimai as state	a causa(s)		
3	· Alase	) n (1)	2019	June 19, 199	7		

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 9.7 DIDOF

					,	Cei	rtificate o			Reg. No.	6	1082
	ı	1. Decedent's Name (First,	Middle, Last)						2. Dete of De	eeth		3. Time of Deeth
Physician /Medica		SUSIE CATH	ERINE	MYERS					June	23	Yeer 997	9:45 PM
Examine	-	4e. Facility Neme (If not inst	itution, give s	treet end numb	er)			4b. City, Town, o	r Location of Dea			, , , , , , , , , , , , ,
		Doctors	Commun	ity Hos	pital			Lank		Princ	e Ge	orges
Funeral Director		5. Social Security Number 219-56-1060	6. Sex 1 □	M 2⊠ F 7.	Age (In yrs. 79	last birthday) Yrs.	If Under 1 Yes Months Dey		n. (Month, D	rth	9. Birthpl Coun	lece (State or Foreign try)
2 .	-	Usuel Residence of Decede										
anyla show ad at	-				10c. City	y, Town or Lo	cation				10	0d. Inside City Limits  1ĬĎ Yes 2□ No
or 28a-f s be notified		MARYLAND PRI  10e. Street end Number	NCE GE	ORGES	GRE	EENBEL						
			OAD	*			10f. Zip Code			10g. Citizen of W		
fler death v	2	44R RIDGE R		2. Was Decede	nt Ever in U	S 13 1	20770		Specify Ves or N	UNITED S	ES an Indien,	
r ther oliner	3	1 Never Married 2		Armed Force	s?	1		f Hispenic Orlgin? ( uban, Mexican, Pue	rto Rican, etc.)	Black	, White, e	
Exan		3 ₩ Widowed 4 Dive	orced	If Yes, Give Yeer or Date	s:		1□Yes 2ሺN	o Specify:		Specify:	W	HITE
ygiene. ygiene. ner than "naturn t, the Medical.		15. Dec (Specify only f	edent's Educ			16e. Deced	lent's Usual Occ	upetion ne during most of w	orkina	16b. Kind of Bu	siness/Ind	ustry
han han	1	Elementary/Secondary (0-		College (1-4d	or 5+)	life. I	DO NOT use reti	red)	Orking			
flled within Hygiene. ther then int, the Me	3	17. Fether's Name (First, Mi	ddlo Lost)			HOUSE	EWIFE	do Marta da Ni		OWNED		<i>t</i>
272 2	ונ									n, Maiden Sumeme	9)	
Monte of Merri	-	19a. Informent's Name/Rele				10h Mailir	a Address /Stre	MINNII et end Number or F		HATFIELD	State Zin	Code
allh ar 27 is r trau		ALICE L. HAL						AY DR., I				20770
F Head	-	20a. Method of Disposition				lace of Dispo	sition (Neme of		Date	20c. Location - 0		
Page ient o		1 Burial 2 ☐ Crema 4 ☐ Donetion 5 ☐ Oth	tion 3 □Re er <i>(Specify)</i>	moval from Sta	te		natory or other p		6/27/97	יייייי אים פ	OD	MADNIAND
permit. Pa Departmen Important: any Injury once.	ļ	21. Signeture Funeral Se		-	1101	22	. Name end Add	ress of Fecility			JUD,	MARYLAND
8.8 5 8		Naun X	ish	_				COLN FUNI DENSBURG			MD	20722
	7	Part. Enter the diseas shock, or heart feilure.	e, or complic	ations thet caus	ed the death	n. Do not ente	er the mode of d	ying, such as cardia	ac or respiretory e	errest,		Approximate Intervel Between
Physician	1	or rough to the control of the contr	List only on	00030 011 0001	O (							Onset end Death
/Medical Examiner		Immediate Ceuse (Final disease or condition	A		Sep	tec >	Short					5 HRS
		resulting in death)			Due to (or	r as e conseq	uence of):			^		. ,
executed in and hel-transit			b.		Usch	me	a gr	ngren	5	ml	1	24 hrs
execunate and and selecting		Sequentially list conditions, if any, leading to Immediate			Due to (or	r es e conseq	uence of):	,0			1	210
The lew requires thet the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use es the bunel-transit completed by Physician/Medical Examin		Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events	С.		Buetolor	es e consequ	tshu	h				Sarys
ng phy es th	3	resulting in death) Last			200 10 (01	00 0 00113641	261106 01).					•
et the death certi			d.									
e dea the at hed fc		Pert II. Other significant cor	ditione cont	ributing to death	but not resu	ulting in the ur	nderlying cause	given In Pert I.	23b. Did	tobacco uee con	tribute to	the cause of death?
v requires that the debean signed by the should be detached		Rosa	1:0	0					1□	Yes 2 No	3 🗆 Prob	ably 4 Unknown
signe d be d		100	8	my.	1 (	, ,			04-144-		04h 14/o	an automorphic diame
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has ge 2			0		V					_/		leeth?
ifficate for, pa		25. Was case referred to me	dical							Yes 2 IMNo	1 🗆	lYes 2□ No
hysicien: The lew his certificate has tal director, page 2 s	1	examiner?	-	spitel: 1 Inpe	tient 2 🗆 I	ER/Outpetien	t 3□ DOA	thar.	eath (Check only	one) idence 6 □Othe	r /Cnasih	
a Physical control of T. T.		27. Manger of Death		28a. Date of Ir	njury	28b. Time of	28c. In	ury et	_	how injury occurre		<u>/</u>
atio		1 ☑Naturel 5 ☐ Pe 2 ☐ Accident in	ending restigetion	(Nortal, L	Dey Year)	Injury	1	ork? □Yes 2□No				
tal or Attending P rs effer death. al Director: After t led in by the funer. Certification:		3 ☐ Suicide 6 ☐ Co	ould not be termined		Injury - At ho		et, fectory, offic	9		Street end Numbe wn, Stete)	r or Rurel	Route Number,
rai Di												
To the Hospital or Attanding Physicien: within 24 hours effer death. To the Funeral Director: After this certifical completely filled in by the funeral director, Medical Certification: To Be (		29a. Certifier 1 ☑ Certifier (Check only one)	ifying Physi Icat Examine	cian: To the bes or: On the basis and manner	or examinet	vledge, deeth ion end/or inv	occurred at the estigation, in my	time, dete and pled opinion, death occ	e, end due to the curred et the time,	ceuse(s) end mer date end place, e	ner es ste nd due to	ited. the cause(s)
To the vithin To the somple		29b. Signature end title of ce	rtifier	and mainer	overed.		29c. Lice	nse number		29d. Date signed	(Month, E	Jey, Year)
		41.00	100	2 1			7	06 33		8/30	97	
(In)		30. Name end eddress of pe	son who con	npleted cause of	f deeth (Item	23a) (Type, I		U		2/24	0/	
9		WILHELMINA M	. CRUZ	, M.D.,	7700	OLD BI	RANCH AV	ENUE, #D	205, CLI	NTON, MD	207	735
State		31. Date filed (Month, Day, )	'ear)	32, Regis	strer's Signet	ure				,		
Registrar		JUN 26	1997	feed	Twels	Rarlall						

DHMH 16 Ray 6/95

Division of Vital Records, P.O. Box 68760,

\* . .

### Please Type or Print in Black Indelible Ink. Assure All Copies Are spible 2 | 086

					Certifica	ate of	Death		Reg. No.				
Physic	ian	Decedent's Neme (First, Middla, La	•					2. Date of Dea	ath Day	Yaar	3. Time o	of Death	
/Medi		Preshasa Ort	iz					May		97	2:25	P.M.	
Exami	ner	4a. Facility Name (If not institution, giv					4b. City, Town, or	Location of Daath	4c. County	y of Daath			
		St. Mary's Hospi	tal				Leonardt	own	St. M	lary's			
Funeral Director		n/a	Sex 7. Ag	a (In yrs. last b	Yrs. If Un Month	der 1 Year ns Days	If Undar 24 Hrs Hours Min 2			9. Birthple Count Mary	ace (Stata e try) land	or Foreig	
pur *		Usual Residence of Decedent  10a. State 10b. County		10c City To	wn or Location					140		21. 11. 1	
the Marylan 28e-f show	-	Maryland St. Ma	ry la		xington	Danle				10	od. Inside C	2 No	
Ne N 1889-1	ct		1 y 5	T.C.							1 1 105	2 100	
1 0 g	i	10e. Street and Number			10f.	Zip Code			10g. Citizan of	What Count	ry?		
eth w	<u>a</u>	45999 Great Mill	s Court			2	0653		United	State	S		
filed within 72 hours efter deeth with the Maryland Hygiene. ther than "natural", or Items 23a or 28e-f show int, the Modical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedant Armad Forces? 1  Yes 2 I				dispanic Origin? (S an, Mexicen, Puer Specifi <b>Puert</b>		14. Rad Bla Specif	ce - Amarica ck, White, e			
urel'	d b	3 Widowed 4 Divorced	Yaar or Dates:					.o recent	Black				
naturel', or	Completed	15. Decedent's Ed (Spacify only highast gra	ducetion ida com <i>plated)</i>	168	a. Decedent's U (Giva kind of	sual Occup work dona	supation a during most of working red)		16b. Kind of Business/Industr		ustry		
Pan in	I du	Elementary/Secondary (0-12)	College (1-4or 5	5+)			d)						
led v lygie lygie rt. m	ပိ	n a			n a	a			n a				
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, he M	Be	17. Fathar's Nama (First, Middla, Last)					18. Mothar's Na	ma (First, Middla,	Maidan Sumar	na)			
Men Men arke	2	Lamont Ortiz					Leslie	Maria Ca	rter				
2 6 8 6		19a. Informant's Name/Relationship (	Type, Print)				and Number or R						
CENL		Leslie Maria Car	ter, Mothe	er 4	5999 Grea	t Mill	s Court, L	exington P	ark, Mary	yland 2	0653		
of Healt Item 2 other		20a. Method of Disposition		20b. Place (	of Disposition (fary, cramatory of	Vama of	ce)	Date	20c. Location	- City or Tov	vn, State		
Pege ent c		1 ■ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif			s Memoria			6-2-1997	Leonardto	was Mar	har Iva		
permit. Peges Department of Important: If it any injury or once.		21. Signatura Funeral Service Licer		CARLICA			ss of Facility						
permit. Peges Department of H Important: If ite any injury or of		Edward N. Brinsfie	SUR	052			Bri	nsfield Fu Leonardtow				9	
		Edward N. Brinsfield, Jr., M00052 22955 Hollywood Road, Leonardtown, Maryland 20650–02  23a. Part1. Enter the disease, or complications that ceused the death. Do not enter tha mode of dying, such as cerdiac or respiratory arrest, Interval Enterval											
Physician											Onset and	Death	
/Medical	Ш	Immediate Cause (Final disease or condition	Promi		1 10 2 4 4					1 9			
Examiner		resulting in deeth)  Due to (or as e consequence of):											
	ě		C L	Due to (or as e	Consequence	J17.				1	e 1		
requiras thet the death certificete be executed een signed by the ettending physicien and hould be detached for use as the bunel-transit	Examiner	Convention that are divised.	b. Chorit	Due to (or as a consequence of):						8 hour	S		
exec n an jel-tr	EX	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
sicle bur		Cause (Disease or injury that initiated events	c										
phy s the	Medical	resulting in daath) Last		Due to (or as a	consequence o								
ding se e	3		d										
ettendin for use	iar									1			
e de the de de	Physician/I	Part II. Other significant conditions of	ontributing to death bu	ut not resulting	in the underlying	g cause giv	an in Part I.	23b. Did t	obacco uae co	ntributa to	the cause	of death	
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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 2 1 0 8 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Yeer James Lester Pugh June 28 1997 1402 /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral**  Birthplace (Stete or Foreign Country) Deys 113 M 2□ F Yrs. Director 217-18-1823 March 24 1906 North Carolina Usuel Residence of Decedent filed within 72 hours efter death with the Maryland 10a, State 10b. County 10c. City, Town or Location "natural", or Items 23a or 28a-f show soldal Examiner name be notified at 10d. Inside City Limits MD Director Ceci1 Conowingo 1 ☐ Yes 2 No 10e, Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1083 Rock Springs Rd 21918 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 ☐ Never Married 2 Married 21215-0020 White 1 ☐ Yes 2 ② No Specify: Completed by 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene Important: If them 27 is marked other than any injury or other traumatic event, the Management of Elementary/Secondary (0-12) College (1-4or 5+) Signalman 6 Railroad Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 2 should be fi end Mental F Ambrose Pugh Dehli Roup Pages 1 and 2 should 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Shirley A. Horton, Daughter 1082 Rock Springs Rd. Conowingo MD 21918 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Belair Memorial Gardens 7-1-1997 21. Signature of Funeral Service License 22. Name end Address of Fecility R. T. Foard Funeral Home, P.A.

111 S. Queen St. Rising Sun MD 21911

Set only one ceuse on each line. 23a. Part1. Enter the dis Approximete Intervel Bety Onset end Death **Physician** /Medical Immediete Ceuse (Fine) disease or condition resulting in death) Examiner Physician/Medical Examiner 418/10 515 The law requires that the death certificate be executed for use as the burial-transi Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): Box 68760. Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contributa to the cause of death? signed by t 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? filled in by the funeral director, page 2 should 24a. Wes en eutopsy performed? of Vital or Attending Physician: 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Aftar Division 5 Pending investigation 1 Yes 2 No To the Hospital or Attendi within 24 hours aftar daath. To the Funeral Director: A 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

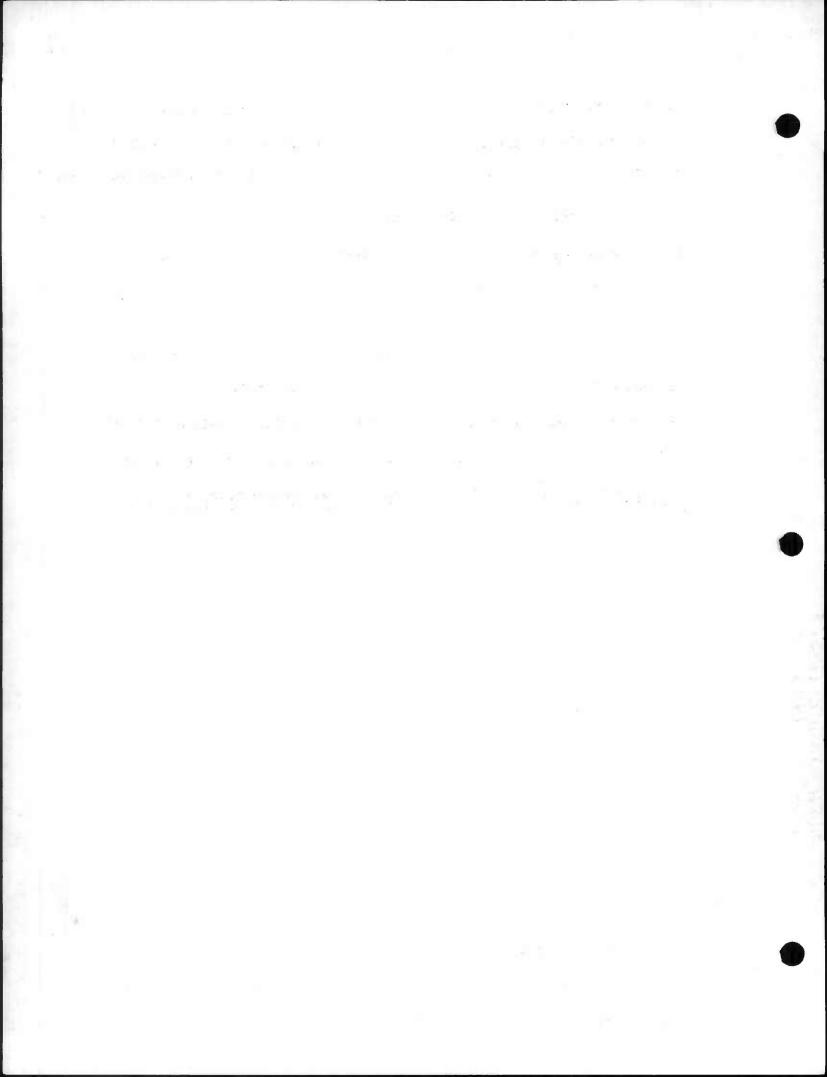
2 Medical Exeminer: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end manner stated. 29a. Certifier Medical (Check only one) 29b. Signature end fitte of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 31. Date filed (Month, Day, Yeer) State Registrar

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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Jegible State of Maryland / Department of Health and Mental Hygiene 2 1 0 8 8

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Counth Dey **Physician** Month Clarence Merton Palmer 6:56 p.m. 16, 1997 June /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 512 Towely Court Lexington Park St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1. M 2□ F 004-22-1288 69 Yrs Director Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Health end Mental Hygiene. Important: If item 27 is marked other than "neture!", or items 23e or 28e4 show any injury or other traumatic event, "Is Medical Examiner must be matted." 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland St. Mary's Lexington Park 10e. Street end Number 10f. Zip Code 10g. Citizen of Whef Country? Funeral 512 Towely Court United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ■ Yes 2 □ No If Yes, Give Yeer or Detes: 1946—1949 Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marifel Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ■ No Specify: Specify: White þ 3 ☐ Widowed 4 ■ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Field Engineer Defense Contracting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be John Davis Palmer Blanche Gertrude Rogers 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Phyllis M. Charles, Sister P.O. Box 5, Brownfield, Maine 04010 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ■ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-18-97 Alexandria, Virginia Metropolitan Crematory 22. Name end Address of Facility Brinsfield Funeral Home, P.A. 2955 Hollywood Road, Leonardtown, Maryland 20650–0279

29a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) **Examiner** burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury thet initiated events resulting In deeth) Lest Due to (or as e consequence of) Clarence Palmer Division of Vital Records, P.O. Box 68760, ettending physician for use es the buria Physician/Medicai Due to (or as e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t lin Dependent Diabeter Helletus 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? Be Completed 24a. Was en eufopsy performed? 1 Yes 2 No Hospital or Attending Physician: 24 hours efter death. 25. Was cese referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Netural 2 Accident 5 Pending investigation To the Hospital or Attendit within 24 hours efter death.
To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) end manner es steted.

Medical Examiner: On the best of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) tones, M.D. 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Dr. Beltsville Und 20705-1757 Gary W. Jones MD 11305 Pitsea 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State Jelia Daveles Rardall Registrar

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene / Certificate of Death 1. Decadent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Day 1997 **Physician** Francis Potter June 10, 5:47 AM /Medical 4e. Fecility Nama (If not institution, giva straet end number) 4b. City, Town, or Location of Death 4c. County of Daeth Examiner 22680 Cedar Lane Court, #1214 Leonardtown St. Mary's 7. Aga (In yrs. last birthday) if Undar 1 Yaar 8. Date of Birth (Month, Dey, Year) Birthplece (Steta or Foreign Country) **Funeral** Months Days Hours 15 M 2□ F 88 579-16-8974 Director Apr 14, 1909 Maryland Usual Residence of Decedent death with the Maryland 10e. Stete 10b. County 10c. City. Town or Location ehow 10d. Inside City Limits Nem 27 is marked other then "naturel", or Nems 23a or 28a-f ehov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director St. Mary's Maryland Leonardtown 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? 22680 Cedar Lane Court #1214 20650 U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yas, specify Cuben, Mexican, Puarto Ricen, etc.) 14. Race - Amarican Indien. Bleck, White, etc. filed within 72 hours after 1 Naver Married 2 Married 1 XYes 2 No If Yas, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🖾 No Specify: 2 White 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pagas 1 and 2 should be filed withir Dapartmant of Haalth and Mental Hygiana. Important: If Nem 27 is marked other then eny Injury or other traumatic event. Ithe Market of the Informatic event. Elementery/Secondary (0-12) 8th Grade College (1-4or 5+) HVAC Engineer U.S. Government 17. Fethar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Edward Rich Potter Clara Mae Twilley 2 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Alice D. Lavender/Niece 22030 Society Hill Road, Leonardtown, MD 20a Method of Disposition 20b. Plece of Disposition (Neme of Deta 20c. Location - City or Town, Stata cemetary, cremetory or other plece) 6/13/97 1 Burial 2 □ Cramation 3 □ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) George Isl. Un Meth. Cem Piney Point, MD 22. Neme and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Signetura of Funeral Service License P.O. Box 270, Leonardtown, Maryland 20650 23a. Part1 Part1./Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximeta Interval Between Onsat end Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es a consequence of) Examiner certificata be axecuted usa as the burial-transi Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequance of): P.O. Box 68760. signed by the attending physician be deteched for use as the buria Physician/Medical Dua to (or as a consequence of) fo Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Records, by 24b. Were eutopsy findings available prior to Completed 24a. Was an autopsy peen performed? completion of cause of deeth? cartificate has Tha 2 NO 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this cardilics 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home Hospital: 0 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 27. Menner of Death
1 ■ Naturel
2 □ Accident 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending invastigation 1 ☐ Yas 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Š 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) end menner es stated.

Medical Examiner: On the base of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceusa(s) and manuer stated. Medical (Check only one 29b, Signature and title of pertibe 29c. Licanse number 29d. Date signed (Month, Day, Year) 30. Name and address of erson who completed cause of Spath (Item 23a) (Type, Print)

California, MD 20619

Registrar

James L. Boyd, M.D.

JUN 12

32. Registrer's Signature

John Daviden Rardall

31. Date filed (Month, Day, Year)

The Contract of the Contract o

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 1 2 1 0 9 0

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day Vasi **Physician** EVELYN PUGH 21 1997 16:45 TUNE /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Johns Hopkins Hospital
5. Social Security Number 6. Sex Baltimore City

9. Birthplece (Stafe or Foreign Country) Baltimore If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Days Hours 1 M 2 TF Vrs 69 Jan. 1, Director 1928 Maryland 217-20-5254 Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter death with the Meryland nent of Health end Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23s or 28s-f show ury or other traumatic event, the Medical Examine must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 XNo MD Carroll Sykesville 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 1780 Pine Knob Road 21784 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Raca - Americen Indien, Black, White, etc. 11. Maritel Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Maryland 21215-0020 1 ☐ Yes 2X No Specify: þ Specify White 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Photographer Photography 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Frank Pugh Lillian Cullison 2 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Edna Cook (Sister) 311 Grand Avenue Front Royal, VA 22630 Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2X Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) Carroll Cremation Serv. 6/23/97 Hampstead, MD 21. Signature of Funeral Service Licenses 22. Neme end Address of Fecility HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400 23e. Part1. Enter the disease, or complications that claused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause of each line. Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Finel diseese or condition resulting in death) /Medical O. MYOCARDIAL INFARCTION Examiner TEN DAYS Due to (or es e consequence of): Physician/Medical Examiner FAILURE NINE DAYS The law requires that the death certificate be executed the buriel-trensit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequence of) Box 68760, . ISCHEMIC LEFT LOWER EXTREMITY Due to (or as e consequence of): 98 for use signed by the e Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probabty 4 ☐ Unknown Division of Vital Records, by 24b. Were eutopsy findings evellable prior to completion of cause of deeth? 24a. Was en eutopsy performed? page 2 should Completed After this certificate hes 1 🗌 Yes 1 TYes 2 No 2 No or Attending Physician: Be 25. Was cese referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 25 No funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 24 hours efter death, Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Phyelctan: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es steted.

| Certifying Phyelctan: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es steted.

| Certifying Phyelctan: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es steted. 29a. Certifier Medical (Check only one) completely within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 21, 1997 Krystn R. Wagner, MD RES-000 JUNE 30. Name end address of person who completed cause of deeth (Item 23a) (Typa, Print) Johns Hopkins Hospital, Baltimore, Maryland 21205 Krystn R. Wagner, 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State JUN 25 1997 Juli Dewilson Parlall Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 2 1 0 9 1

					Ce	rtificat	te of	Death			Reg. No.			
Physic /Med		1. Decedant's Nama (First, Midd Doris Marie	Procto	r						2. Data of Date Month	ath	Yaar	3. 1	Fima of Death 9:11 A
Exam		4a. Facility Nama (If not institution 15300 Brandy)						4b. City, Tov Brand	wn, or Lo	ocation of Daath	4c. Co	unty of Daath		e's
, Funera Directo		5. Social Sacurity Number 219–58–8303	6. Sax 1 □ M 2 🛣 F	7. Aga (In yrs 45	s. last birthday) Yrs.	Months Months			24 Hrs. Min.	8. Data of Birt (Month, Da)			-	Stata or Foraign
r 28a-f show	tor	Usual Rasidance of Decedant  10a. Stata 10b. County  Maryland Prince	e George'		ity, Town or Lo Brandyw						•		10d. Ins	sida City Llmits ☐ Yas 2 X No
th with the	Funeral Director	10e. Street and Number 15300 Brandywi	ne Road			10f. Zip		613			-	of What Cou	intry?	
or items	by	11. Marital Status 1 Navar Marriad 2 Mar 3 Widowed 4 Divorced	ied Armed Fo	24∑ No iva		Was Daced If Yas, spec	cify Cub	an, Maxican	gin? (Spe , Puarto	ecify Yas or No- Rican, atc.)	A	Race - Amari Black, Whita MC11C ecify:		<sub>lian,</sub> India:
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uld be filed Mentel Hygi rked other itic event, i	To Be Co	17. Father's Nama (First, Middle, Thomas Ruben	Last)				., 01	18. Motha		(First, Middle, Cace Tho	Maidan Su	mama)		
and 2 sho alth end !		19a. Informant's Name/Ralations James Francis		Husband	19b. Maili 153	ng Addrass 800 Br	s (Stree Cand	and Numba ywine	r or Rura Rd.	Brandy	r. City or To Vine,	wn, Stata, Zi Maryla	o Coda and	20613
permit. Peges 1 end 2 should be filed with Depertment of Health end Mental Hygiena Department if item 27 is marked other that any injury or other traumatic event, it a gonce.		20a. Mathod of Disposition  1	pecify)	Stata	Placa of Dispondent Place of Dispondent Place of Dispondent Place of Place	tion Nama an	Cem nd Addre	etery ass of Facility	Lee	7, 7, 997 Funeral Ferry 1	Clin L Home	nton, Ne, Inc.	Mary	land
eath certificate be executed  We man estanding physician and properties as the buriel-trensit	/Medical Examiner	Immadiata Causa (Final disaasa or condition resulting in death)  Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Disaasa or injury that initiatad awants resulting in death) Last	c	leta	or as a consag	uance of):	ra fo	tory B.	rai	Arre	st- Par	Knea	8	
thet the d ed by the deteched	y Physician	Part II. Other algnificant condition	na contributing to de	eath but not ra	sulting in the u	ndarlying c	eusa gi	van in Part I.				contributa t		ause of death?
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5 5 2	은	1 ☐ Yas No  27. Manner of Death	Hospital: 1 🗆 I		ER/Outpatien		/A		-	na Rasid			ly)	
E je e	Certification:	Natural 5 Pandin 2 Accidant Invastig 3 Suicida 6 Could r 4 Homicida	ation (Moni	of Injury - At h	28b. Tima of Injury oma, farm, str	М		rk? Yas 2 □ N	ło	28d. Dascribe h	traat and N		al Route	a Num <i>ber,</i>
Hospital 24 hours Funeral rely filled	edical Ce	29a. Cartifiar 1 Certifyin (Check only one)	Phyaician: To the	best of my kno asis of axamina nar stated.	owledga, daath ation and/or Inv	occurred a	at tha tir	na, data and ppinlon, daath	l place, a	ind dua to tha c ad at tha tima, d	ausa(s) and ata and pia	d mannar as s ce, and dua to	tated.	usa(s)
To the within 2 To the comple	Me	29b. Signatura and title of pertiller	- A			29c	Licans	a number 45	12	96	9d. Data si	gned (Month,	Day, Yo	ear)
		30. Nama and address of person of Shamima. Abba.	s, MD 510	0 Auth	Way, C		pri	ngs, M	id 20	746				
Sta	ate	31. Data filed (Month, Day, Year)		egistrar's Signa	atura 🗸									

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State of Maryland / Department of Health and Mental Hygiene 2 1 0 9 2

					Cert	ificate o	f Death	•	Reg. No.		
Physicia	ın	1. Decedent's Nama (First, Middla, L.		0	-2			2. Data of Da Month	100	Year O	Tima of Deeth
/Medica			MILDREF		RICINS	3		JUNE	14	1797	FOUND
Examine	er	4a. Facility Name (If not institution, gi	va straat and numbar		31		4b. City, Town, or			y of Death	
		1011			last birthday)	If Under 1 Year	TEMPLE at If Under 24 Hrs	HILLS 8. Data of Bi		E GEORG	
Funeral Director			1□ M 2□XF 7		Yrs.	Months Day		(Month, D	, 1925	VIRGI	(Stata or Foreign
- S = 1		10a. State 10b. County		10c. Cit	y, Town or Loca	tion				10d. I	nside City Limits
/z nours ener death with the Maryland natural', or items 23a or 28a-f show dical Examiner must be notified at	ţō	MD PRINCE	GEORGES	TE	MPLE H	ILL				X	Yas 2□No
r 28s	<u>2</u>	10e. Street and Number				10f. Zip Coda			10g. Citizan of	What Country?	
e 4		4011 23rd PARK	WAY			20748	8		usa		
if Health end Mentel Hygiene. Item 27 is merked other than "natural", or Items 2 other traumatic event, the Medical Examiner ma	/ Funeral Director	11. Marital Status  1 Nevar Married 2 Married	12. Wes Decedant Armed Forcas 1  Yas 250 If Yas, Giva	?		as Decedant of	f Hispenic Orlgin? (Suban, Maxican, Puarlo o Specify:	pecify Yes or No to Rican, atc.)		ce - American Ir ack, Whita, atc.	
l Ext	d by	3 ☑ Widowed 4 ☐ Divorced	Yaar or Dates:						Speci		
nath	Completed	15. Decedent's E (Spacify only highast gr	ducation ada complated)		16a. Deceder (Giva ki	nt's Usuai Occ nd of work don	upation a during most of wor red)	rking	16b. Kind of E	Business/Industr	у
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Hygi Her If,		17. Father's Nema (First, Middle, Las	t)		- 011	D I.(I.(	18. Mother's Na	ma /Firet Middle		OFFIC	E
Mentel arked o atic eve	o Be	LLOYD WALLER	*				WILLIE			me)	
mert met	P	19a. Informant's Name/Relationship	(Typa Print)		19h Mailing	Addrass (Stra	at and Number or Ru			State Zin Con	fo.)
m 27 is me				\			CK TERR				rei/
Hea tem Sther	ŀ	20e. Mathod of Disposition	DAUGHTER	20b. P	lace of Disposit	ion (Name of		Data		- City or Town,	State
0		1 ☐ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Space		MAR	ematary, crama YLAND	tory or other p. VATION		UN 21,			
Depertment of Health Important: If Item 27 any injury or other tr once.		21. Signature of Funaral Sarvica Lica	-		22. 1	lame and Add	rass of Facility			HOILE	MD
Depentr Importa any inju		23a. Pert1. Entar the diseasa, or comshock, or heart failure. List only	Melia	77-	5	17 11t	h STREE	T S.E.			
	cal Examiner	disease or condition rasulting in deeth)  Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Causa (Disease or injury that initiated awants	b	Due to (o	r as a conseque	ence of):	erotic (		75000	IN VISAR	×
0.0	an/Medical	rasulting in death) Last	d	Dua to (or	as a conseque	nce or):				i i i	
ed fo	Sicia	Part II. Other significent conditions	contributing to death t	out not rasi	ulting in tha und	arlying causa g	givan in Part I.	23b. Dld	tobecco usa co	ontributa to the	cause of death?
	by Physician/							1 🗆	Yes 2□ No	3 Probably	4 Unknow
hes been signed 2 should b	Completed							24a. Was	an autopsy ormed?	availab	utopsy findings ia prior to tion of causa h?
this certificate has been signed by the ettending physician end rai director, page 2 should be detached for use as the burial-transit.	5							1 🗆	Yas 2 No	1 □ Ya	s 2 No
certificate rector, peg	Be	25. Was case referred to medical axaminar?					26. Plece of Dea	ath (Check only	one)		
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obath. ctor: After th y the funeral		27. Magnar of Deeth  1 Neturel 5 ☐ Pending 2 ☐ Accident investigation	28a. Deta of Inju (Month, De	iry ly Year)	28b. Tima of Injury	28c. Inj W M 1[	ury at ork? □ Yes 2 □ No	28d. Dascribe	how injury occu	rred	
		3 ☐ Suicida 6 ☐ Could not b	28a. Place of in	ury - At ho c. (Specify	ma, farm, straa	t, factory, office	8	28f. Location ( City or To	Street and Num wn, Stata)	bar or Rural Ro	uta Number,
In Director: After ad in by the fune	Certific	4 ☐ Homicide datarmined	building, a								
• Funeral Directo	dical Certification:	4 ☐ Homicide datarmined	nysician: To the best miner: On the basis of and manner si	f axa <i>m</i> inat	wledga, daath o ion end/or invas	ccurred at the tigation, in my	tima, data and piaca opinion, daath occu	, and due to tha rrad at tha tima,	causa(s) and m data and piaca,	ennar es stated and dua to tha	causa(s)
in 24 hou he Funer pletely fill	Medical	4 Homicide datamined  29a. Cartifliar (Check only one)  29b. Storiature and title of certifling	nysician: To the best miner: On the basis of and manner st	f axa <i>m</i> inat	ion end/or inves	29c. Licer DEPUT	opinion, death occu	rrad at tha tima,	data and piaca,	and dua to tha	causa(s)
within 24 hours effected To the Funeral Directe completely filled in by the Madical Casalita	Medical	4  Homicide datamined  29a. Cartifiar (Check only one)  1  Cartifying Property Madical Exercises	nysician: To the best miner: On the basis of and manner st completed cause of c	f axa <i>m</i> inat	ion end/or invas	29c. Licer DEPUT nt)	MEDICA 3395	L EXAMIA	data and placa, 29d. Date signe JUNE	and dua to thated (Month, Dey,	causa(s)

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 2 | 093

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nema (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Day **Physician** 21 1997 9:23 AM Saluda Pearson June /Medical 4a. Fecility Neme (If not institution, give streat end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 9603 Beachwood Avenue Seabrook Prince George's If Under 24 Hrs. 8. Hours Min. Birthplace (Stata or Foraign Country) 5. Sociel Security Number 7. Aga (In yrs. last birthdey) if Undar 1 Year Data of Birth (Month, Day, Year) **Funeral** Months Days 1 ☐ M 2 反 F 577-26-9390 88 Yrs. Director 02-14-09 North Carolina Usual Rasidance of Dacedant the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "naturel", or items 23a or 28a-f shorted with Medical Examiner must be notified at 1 Yas 2 No Directo N/A N/A Washington DC 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 321 Anacostia Avenue, N.E. 20019 USA pemit. Peges 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a any Injury or other traumatic event, the Medical Exempted 2008. Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 14. Rece - Amarican Indian, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 11. Maritel Stetus 1 ☐ Yas 2 💢 No If Yas, Giva Yeer or Dates: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 Black 1 Yes 2 No Specify: ģ 3x Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highest greda complated) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) 10th File Clerk Private 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Be Christanna Lassiter Benjamin Turner Bryant 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 7105 97th Avenue, Seabrook, Maryland 20706 Garnette Saylor/Daughter 20b. Place of Disposition (Name of cematary, cramatory or other piece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 X Ramoval from State 6/27/97 Aulander, NC 4 ☐ Donation 5 ☐ Other (Specify) Bryant Cemetery 21. Signetura of Funarel Service Licenses 22. Nama and Addrass of Facility J.B. Jenkins Funeral Home Percen Na 7474 Landover Road, Landover, Maryland 20785 23a. Pert1. Entar the disease, or complications thet caused the daeth. Do not entar the mode of dying, such es cerdiac or raspiratory arrast, shock, or haart failura. List only one cause on each line. Approximata Intervel Batw Physician /Medical Immedieta Causa (Final disaasa or condition rasulting in death) Neoplasm Etiology Unknown Examiner Dua to (or es a consequance of): Examiner Large Abdominal Mass or Attanding Physician: The law requires that the death certificate be executed physician and the burial-transit Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disease or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of) Anorexia Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es a consequance of): Dehydration signed by the at id be detached for Part II. Other eignificant conditione contributing to death but not resulting in the undarlying ceusa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 thomknown þ 24b. Ware autopsy findings eveileble prior to completion of cause of death? 24a. Was en eutopsy performed? Completed 2 No certificate 1 ☐ Yas 1 ☐ Yes 2 ☐ No Be 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Check only ona) 2 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatlent 3 DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) Certification: 28h Time of 28d. Dascribe how injury occurred 28c. Injury at Work? Affer 5 Panding investigation 1 Natural efter death. Director: Aff 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) in by 4 Homicide To the Hospital within 24 hours a To the Funerel C completely filled 29a. Certifier 1 🕒 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mennar as stated. Medical at Examiner: On the but of exemination and/or invastigation, in my opinion, death occurred et the time, date and place, and dua to the ceusa(s) and manyer stated. 29b. Signature and title of certifi 29c. License number 29d. Data signed (Month. Dav. Year) who completed ceesa of daath (Itam 23a) (Type, Print) 30. Name and address of person Frank B. Doggett, III, M.D. 2815 16th Street, N.E. Washington DC 20018 31. Data filed (Month, Day, Year) 32. Registrar's Signeture State John Studior Revell

**DHMH 16 Rev 6/95** 

Registrar

JUN 24 1997

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						Certific	ate of	Death		Reg. No.		
			1. Decedent's Name (First, Middle, L	ast)					2. Date of D	Death	NII.	3. Time of Death
	Physic /Medi		Nancy ELiza	shoth D.	ainter				June	Day	Year 1447	10:00 A.M
	Exami		4a. Facility Name (If not institution, gi		4,7,0			4b. City, Tow	n, or Location of Dec			170.000
			12207 /1/11	more Lane				B	aurie	Prin	00 1	Manuela
1	Funeral				(In yrs. last birt		nder 1 Year			Birth		place (State or Foreign
	Director		216 38 3296	1□M ¾☐xF	56	Yrs. Mon	ths Days	Hours		22,1940		
	D		Usual Residence of Decadent		50					22,1340	rial	/ Lanu
	ylan		10a. State 10b. County		10c. City, Towr	or Location					1	0d. Inside City Limits
	Me Series	Ş	Maryland Prince	George's	Bowie	:						Yes 2□No
	h th	Director	10e. Street and Number			10f	. Zip Code			10g. Citizen of	What Cour	itry?
	h wil	a l	12207 Wynmore L	ane			2071	5		Unite	d Sta	ates
	within 72 hours efter death with the Meryland ene. than "natural", or items 23s or 28s-f show ha Medical Examiner must be notified at	Funeral	11. Marital Status	12. Wes Decedent Ev Armed Forces?	er in U,S.	13. Was D	ecedent of	Hispanic Origi	n? (Specify Yes or N Puerto Rican, etc.)		ce - Americ	an Indian,
0	of ite	E	1 ☐ Never Married 2 ☐ Married	1 Yes 2 No		_			Pueno Fican, etc.)		ck, White,	etc.
21215-0020	72 hours eft "natural", or	þ	3 ☐ Widowed 4 ☐ Divorced	Yeer or Dates:		11116	s 2 No	Specify:		Specif		nite
2-0	72 ho	Completed	15. Decadent's E	ducation	16a.	Decedent's	Usual Occu	pation during most	of working	16b. Kind of B		
21	within ene. then	g	(Specify only highest gi Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NO	T use retire	9d)	or working			
		5	12	1	Ad	minist	trativ	ve Assi	stant	Hughe	s ST	K Corp.
Pu	be filed tel Hyg d other	Be (	17. Father's Name (First, Middle, Las	1)				18. Mother	s Name (First, Midd			
/la	should be fand Mentel I	To	William Russell	Gray				Ma	ry Hilda	Coster		
Maryland	d 2 should be filed th end Mentel Hygi 7 is merked other traumatic event, I		19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Add	ress (Stree	and Number	or Rural Route Num	ber, City or Town	, State, Zip	Code)
			Mary Adams D	aughter	1	3003 7	Viewpo	oint La	ne Bowie	Md. 2071	.5	
re	othe othe		20a. Method of Disposition		20b. Place of	Disposition y, crematory	(Name of	aca)	Date	20c. Location	- City or To	wn, State
E	Peges nent of I int: If Ite		1 Burial 2 □ Cremation 3 ( 4 □ Donation 5 □ Other (Speci						ine 25,199	7 Pikes	2771114	b Md
Baltimore,	permit. Peges 1 and Depertment of Heelth Important: If Item 27 any Injury or other ti		21. Siggatuse of Funeral Service Lice		Diala	1						
Ö	De la la		VANDA.11	1) 1) .			Robe	ort E	. Evans	-uneral	Hom	e, Lie.
	_		23a. Fart 1. Enter the disease, or con	nolication that caused th	ne death. Do n	ot enter the	1 4 0 0 0 mode of dv	ing such as c	apolis R	cl. DOW	ie me	Approximate
	Dhusislan		23a. Fart1. Enter the disease, or con shock, or heart failure. List only	one cause on each line.								Interval Between Onset end Death
	Physician /Medical		Immediate Cause (Final			, ,	, .	1				
1	Examiner		disease or condition resulting in death)	a	met	astn.	tic	/un	g can	ncer		2413
		ē		Dŧ	ue to (or as a c	onsequence	of):		V			,
	nsit	Examiner		b							<u> </u>	
	The law requires that the death certificate be executed at hes been signed by the ettending physicien end page 2 should be deteched for use as the buriel-transit	Xal	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events	Du	ue to (or es e d	onsequenca	of):				į	
68760,	sicler buri		Cause (Disease or Injury	c	2. A 1808		6					
89	ficate phy s the	Medicai	resulting in death) Last	Du	ue to (or es a c	onsequence	of):					
Box	oertific anding p			d								
ă	leath ce ettendi for use	Physician	Dod II. Other elselfleant conditions						001 01	44.4		
P.O.	res thet the de signed by the e be deteched t	nys	Part II. Other significant conditions	contributing to death but	not resulting in	the underlyl	ng cause g	wen in Part I.				the cause of death?
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of Vital Records,	uires sigr	d by							24a. Wa	is an autopsy	24b. W	ere autopsy findings
Ö	v require been si shoufd	iete							per	formed?	CO	eilable prior to mpletion of cause
Re	hes hes	Completed									of	death?
<u></u>									10	Yes 2000	1 [	Yes 2 No
V:E	ician: The certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				-	of Death (Check only	/ one)		
of	hysi this c	7	1 Yes 2 No	1 L Inpatient	2 □ ER/Ou		DOA		sing Home 5 Defe			y)
Ë	il or Attending Perestration of the color of the function of the funeral of the f	Certification:	27. Manner of Deeth 1 Natural 5 □ Pending	28a. Data of Injury (Month, Day )	(ear) 28b. T	njury	28c. Inju			e how injury occur	red	
Sign	tend death tor: /	cat	2 Accident investigation 3 Suicide 6 Could not t			М		Yes 2□N		(0)		16
Division	l or Attendi efter death. Director: A i in by the fu	ŧ	4 ☐ Homicide determined	28e. Placa of Injury building, etc.	/ - At home, fa: (Specify)	rm, street, fa	ctory, office	1	281. Location City or T	(Street and Numi own, State)	ber or Hura	I Houte Number,
	ospital hours e uneral C		20. 0									
	Hosp 24 ho Fune fely f	edicai	29a. Certifier (Check only one)  1 Certifying Plants one)	hysicien: To the best of r miner: On the basis of ex	xamination and	, death occur Vor Investiga	red at the t tion, in my	ime, date and opinion, death	placa, and due to the cocurred at the time	e cause(s) and m e, date and place,	anner as si and due to	tated. the cause(s)
	To the Hospital or Attending Physician: whin 24 hours efter death. the Funeral Director: After this certific completely filled in by the funeral director.	Med	Grie/	and manner state	d.							
	-			in and	riysie	-4-01	7	) 1/20	63	1 - 7	- month	2 (7)
	(00)		Dand q,	Bockelin	r, K	n.D.	10	100		6-2	2-9	
1	20/		29b. Signature and title of certifier  Dound Q,  30. Name and address of person who  Dound A, Bo	completed cause of dea	th (Item 23a) (	Type, Print)		111	1 5	- 1	the	W 20715
			31. Date filed (Month, Day, Year)	croner 1	Cionatura	173	00	Ja119	m T FO)	cun,	- //	, isome
	Sta Registi		JUN 24-199	32 Registrar	o Signature	white						
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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 2 1 0 9 5

					C	ertificate of	Death	F	Reg. No.		
	Physici	an	1. Decedent's Neme (First, Middle, La	ist)				2. Dete of Dee	eth Dey	Yeer	3. Time of Death
	/Medi		ANNA	Μ.		REID		6	5 (	97	820A
	Examir		4e. Fecility Neme (If not institution, gi		INTER		4b. City, Town, or SALISBU	JRY	W	of Deeth	СО
	Funeral Director			Sex 7. Age (In yrs. 1	last birthde Yrs.	y) If Under 1 Year Months Deys	Hours Min.	8. Date of Birth (Month, De) 03/15/1	, Year) .927		lece (State or Foreign htty) TUCKY
	Aerylend f ahow	ō	10a. State 10b. County		ty, Town or I					1	0d. Inside City Limits 1 ☐ Yes 2 Ø No
	tha h	Director	MARYLAND SOMERS  10e. Street end Number	EI P	RINCES	SS ANNE 10f. Zip Code			10g. Citizen of	Whet Cour	atry?
	3a or		12623 EAST RIDGE	ROAD		21853			U.S.		,
0200-61212	72 hours after daath with tha Maryland natural', or flems 23a or 28s-f ahow dical Examinet must be notified at	by Funeral	11. Maritel Stetus  1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes:	I,S. 13	I. Wes Decedent of I If Yes, specify Cub		pecify Yes or No- to Rican, etc.)	14. Rec Ble	ca - Americ ck, White,	etc.
<u>ဂ</u>	"natural", c	ted	15. Decedent's E (Specify only highest gr	ducation	16a. Dec	edent's Usuel Occup	pation	rkina	16b. Kind of B	usiness/inc	dustry
7	d within giene. rr then "	Completed	Elementery/Secondery (0-12)	College (1-4or 5+)		re kind of work done DO NOT use retire	d)	ning			
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Maryland	Mantal H Marked ot affic ever	Be	17. Fether's Neme (First, Middle, Las) ELBERT RYLE	)			EFFIE V	ne (First, Middle,	Meiden Sumen	10)	
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	C = 0 -		THEODORE REID/HUS	BAND	1262	3 EAST RI		, PRINCES	SS ANNE	, MD.	21853
baltimore,	Pagés ment of ant: If it ury or o		20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci	Removal from State	cemetery, cr	position (Neme of emetory or other ple OD CEMETE		Dete 6/24/97	20c. Location -		
	Physician /Medical Examiner	Examiner	23 Parts. Enter the disease, or conhock, or heert feilure. List only Immediate Cause (Final disease or condition resulting in deeth)  Sequentially list conditions.	e. myocar Due to (c	th. Do not e	INMAN FUN 1673 SOME nter the mode of dyl equence of): n 0 5 1 5 equenca of):	RSET AVE	PRINC	ESS ANN		Approximete Interval Between Onset end Death
. DOY DOY DO,	deeth certificata be axecuted na attending physician and ed for usa as the bunal-transit	Physician/Medical Ex	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in deeth) Lest	d	er es e conse	equence of):	ease.	23b. Dld t	obacco usa co	entribute to	o the cause of death?
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or vital necords,	The law requires that tha deeth cer ata has been signed by the attendir paga 2 should be deteched for usa	Completed by	Lisease	SNIMIC 9 87	Mach	ive pain	mory	24a. Wes a	an eutopsy med?	COL	ere eutopsy findings eileble prior to mpletion of cause death?
č	The lav	EO.						1 D Y	es 2 No	10	]Yes 2□No
0	ysician: The li s certificata he director, paga	Be C	25. Wes case referred to medical examiner?				28. Place of Dec	eth (Check only o			
>	Physician: rthis certificaring director,	To	1 Yes 2 No	Hospitel: 1 Nopatient 2 -	ER/Outpetic	ent 3 DOA Oth	her: 4 Nursing H	lome 5 ☐ Resid	ence 6 D0th	er (Specify	y)
	nding Pt ath. :: Attar th a funara		27. Manner of Deeth  Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injury (Month, Dey Year)	28b. Time Injury	Wo	ry et rk? ∣Yes 2 □ No	28d. Describe h	ow injury occur	red	
DIVISION	To the Hospital or Attending Physical within 24 Hours after death.  To the Funeral Director: After this complately filled in by the funeral di	Certification:	3 Suicide 6 Could not be determined		ome, ferm, s	street, fectory, office		28f. Location (S City or Tow		er or Rura	l Route Number,
	n 24 hou n 24 hou ne Funer	edicai	29a. Certifier (Check only one)	nysician: To the best of my kno miner: On the basis of examina end menner steted.	wledge, dea tion end/or l	ath occurred et the tid investigation, in my d	me, dete end plece opinion, deeth occu	e, end due to the d arred et the time, d	euse(s) end modete end place,	end due to	eted. the cause(s)
	To th To th comp	Me	29b. Signatury and tale of certifier	,		29c. Licens	_		29d. Date signe	d (Month,	Dey, Year)
)			Jales Chin	om in			30823		6/21	197	
			30. Name and address of person who	completed cause of death (Item	n 23e) (Type	PRMC	-				
	Sta Registr		31. Date filed (Month, Dey, Year)	32. Registrar's Signa	guellar.	Randall					

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State of Maryland / Department of Health and Mental Hygiene 97 2	U	9	

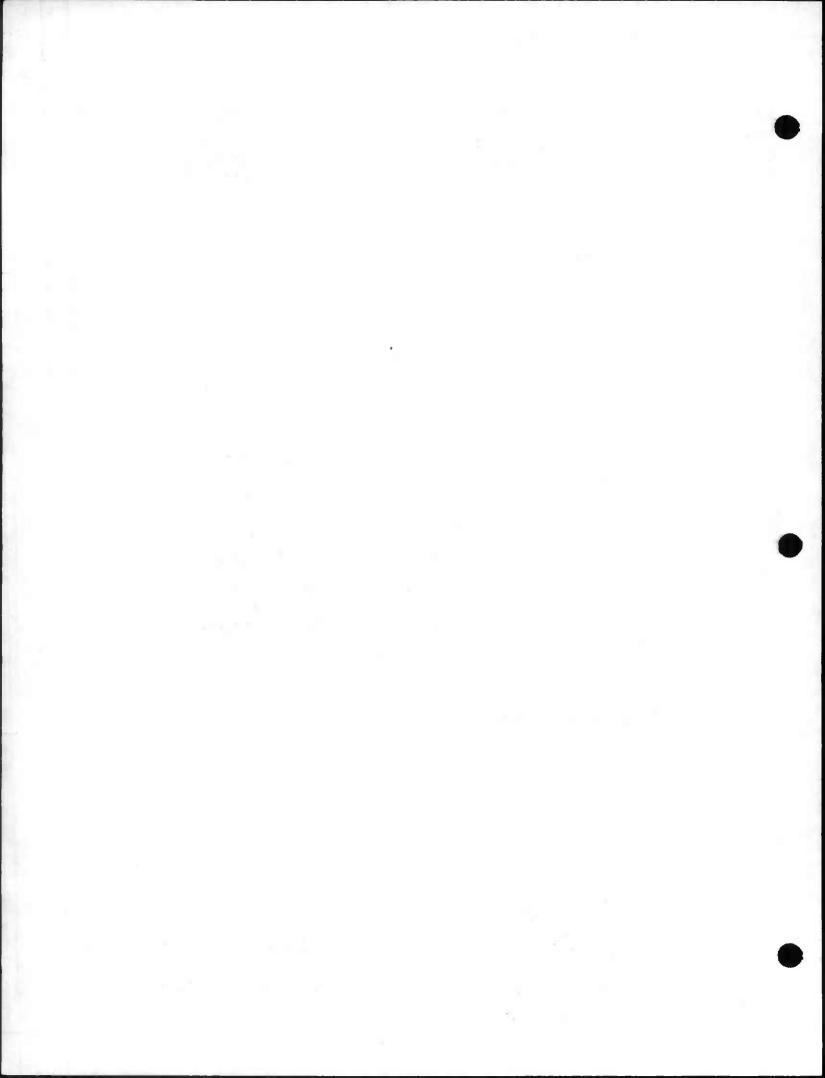
						Cer	tificate of	Death			Reg. No.			
	L-11.		1. Decedent's Name (First, Middle, L.	est)						2. Data of De		Year	3. Time	of Death
	Physici /Medic		Ruth	Т	Reese					June 1	9, 1997	real	3:25	A.M.
	Examir		4a. Facility Name (If not institution, gir	re street end number)						ocation of Death	_	y of Death		
			Home- 4958 Cana				If Under 1 Yaa	Cris		_		erset		MIII 2 - 9997
L	Funeral Director			Sax 7. Ag 1 □ M 2 2 1 F	a (In yrs. last bir 60	Yrs.	Months Days		Min.	8. Date of Bird (Month, Da May 2,	y, Year)		place (Statentry) ylanc	e or Foreign
	Mot to		10e. State 10b. County		10c. City, Tow	n or Loc	cation						10d. Inside	City Limits
	Men	tor	Maryland Somer	set	C	ris	field						1 □ Y	as 2∭ No
	h with the 23a or 28	Funeral Director	10e. Street and Number 4958 Canal Drive	<u>-</u>			10f. Zip Code	21817			10g. Citizen of U.S		ntry?	
21215-0020	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Meryland Depertment of Heelth and Mental Hyglene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any futury or other traumatic event, the Medical Expiri ner must be notified at once.	Ď	11. Marital Status  1 □ Never Married 2 ☑ Marriad  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yas 2XI If Yes, Give Year or Dates:			Vas Decedant of Yes, specify Cul □ Yas 2X No			ecify Yas or No Rican, etc.)		ce - Ameri ick, Whita, fy: Whi		H
2-0	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation ede completed)	16a.	Deced (Give I	ent's Usual Occu kind of work done OO NOT use retin	pation during mos	t of work	ing	16b. Kind of E	Business/Ir	dustry	
12	within	d E	Elementery/Secondery (0-12)	Cotlege (1-4or 5							M- 23			
	filed v Hygie thar t	ပိ	H. S. Graduate  17. Father's Name (First, Middle, Las	3 Years	Re	gıs	tered Nu	1	er's Nam	e (First, Middla,	Medio Maiden Surna			
Maryland	d be entai	To Be	Albert D. Tawes	,						th Harr				
ary	shoul mark mert	F	19a. Informant's Name/Relationship	(Type, Print)	19b	. Mailin	g Address (Stree					, Stete, Zij	o Code)	
	and 2 eith e 27 is r trac		Richard D. Reese	(Husband)	4	1958	Canal I	rive	- Cr	isfield	, MD	21817		
Baltimore,	Pages 1 e nent of He nt: If itam iry or othe		20a. Method of Disposition  1 XBurlal 2 Cremation 3 [ 4 Donation 5 Other (Speci		cemate	ry, crem	sition (Neme of netory or other pla <b>Fpiscopal</b>		У	Date 6/20/97	20c. Location Marion			
Balti	permit. Depentral Importal any inju		21. Signature of Ednesal Service Lice	Bradek	auf.	B	Name and Addr radshaw	& Son	s Fu			210	17	
	-		Robert H. Bra 23a. Part I. Entar tha disease, or con shock, or heart failure. List only	plications that caused	the death. Do		06 W. Ma or the mode of dy					218	Approxin	
	Physician		SHOCK, OF HEART RAILUTE. LIST OHIS	one cause on each in	ne.								Onset er	nd Death
	/Medical Examiner		Immediate Cause (Final disaase or condition	ME	TASTA	TIC	BR E	AST	CA	NCER				
ū	Examine	Ļ	resulting in deeth)	α.	Due to (or as a					-				
_	led Isit	nlne		b										
_6	el-trai	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (or as a	consequ	uence of):					į		
68760,	e be c	edical	that Initiated avants	C	Due to (or as a o	CORRORI	ience of):							
Box 68	death certificete be executed e ettending physician end ed for use as the buriel-transit	-	resulting in death) Last	d	Due to (or as a c	onsequ	Jence ory.							
-	death cei e ettendir d for use	lcia	Part II. Other aignificant conditions	contributing to death b	ut not resulting in	n the un	dedylno causa o	iven in Part I		23h Did i	tobacco uae c	ontribute t	o the caus	e of death?
P.O.	that the de sed by the e	y Physician/		on induity to doubt o	at not resulting ii	T (IIO GIT	donying oadsa g	THE THE TAIL I	•	1 🗆				Unknown
of Vital Records,	The law requires that the ste has been signed by th page 2 should be deteche	Completed by								24a. Was perio	an eutopsy rmad?	a c	ere autopo vailabla pri ompletion deeth?	sy findings or to of cause
<u></u>		Cor								101	as 20 No	1	☐ Yes 2	2□ No
<u> </u>	ysician: The list certificete hadirector, page	Be	25. Was case referred to medical examiner?	Hospitel:						h (Check only o				
ō	Attending Physician: or death. ector: After this certific by the funeral director,	: To	1 ☐ Yes 2 ☐ No 27. Manner of Deeth	1 LI Inpatie		tpetient Time of	3 DOA	ner: 4□ Nu	irsing Ho	me 5 Resid			fy)	
UIVISION	or Attending efter death. Director: After J in by the fune	tlon	1 Netural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, De	y Year)	njury	28c. Inju Wo	ork? ]Yes 2□	No	28d. Describe I	iow injury occu	rrea		
2	Atten r deal ctor: by the	flca	3 ☐ Suicide 6 ☐ Could not b	e one Place of Inc	urv - At home, fa	rm. stre	et, factory, office			28f. Location (S	Street end Num	ber or Run	al Route N	um ber
5	efter Direction	Certification:	4 ☐ Homicide	building, etc	c. (Specify)	, 00	ot, tastory, other			City or Tov	vn, Stete)			un(150.)
	To the Hospital or Attending Phywithin 24 hours efter death. To the Funaral Director: After thi completely filled in by the funeral	edical (	29a. Certifier 1 Certifying Pt (Check only one)	nyaician: To the best on niner: On the besis of and manner sta	exemination and	, death d/or inve	occurred et the t estigation, in my	ime, date an opinion, dea	d place, th occur	end due to the red at the time,	cause(s) end m date end place,	anner es s	stated. o the caus	Θ(S)
	Vithil To th	M	29b. Signature and title of certifier				29c. Lican	se number			29d. Date sign	ed (Month,	Day, Year	)
			1/2 -	a _	e		D	4809	8		6-19	- 97		
			30. Name and address of person who	completed cause of d	eeth (Item 23a) (	Туре, Р	Print)							
			DR. VIJAY	KARUHE	BUNAT	HAT	V - 201	Hall	High	way - C	risfiel	ld, M	D 21	817
	Sta Registr		31. Date filed (Month, Day, Year)  JUN2 0	32. Registra	ar's Signature	Rand	lall							

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State of Maryland / Department of Health and Mental Hygiene 97 21097

					(	Certifica	ate of	Death		F	Reg. No.		
	Diam'r.		1. Decedent's Name (First, Middle, Li	ast)			_		2.	Dete of Dea	ıth	Van	3. Time of Death
	Physic /Medi		James 1	William	R	ushin	g		J	Month une	Dey 25	1997	12:53p.
	Exami		4a. Fecility Neme (If not institution, gir	ve street end number)				b. City, To	wn, or Locati	on of Deeth			
			Calvert Memor:	ial Hospi	tal		Pr	rince	Fred	erick	c Cal	vert	
1	Funeral Director		578 44 1532	Sex 7. Age	(In yrs. lest birti Y	nday) If Un Monti	der 1 Year is Days	If Under Hours	Min. Ap.	Date of Birth (Month, Dey C. 9	1935	9. Birthpl Count Wash	ace (Stete or Foreign try) • DC
	within 72 hours effer deeth with the Maryland ene. than "naturel", or flems 23s or 28s-1 show to Med cal Examinat must be notified at	ector	Usuel Residence of Decedent  10a. State 10b. County  MD Calvert  10e. Street and Number		10c. City, Town North	Beach							od. Inside City Limits 1∛ Yes 2 □ No
	eth with 123a or 3	Funeral Director	4000 3rd Street			2	Zip Code 20714				USA	Whet Count	try?
21215-0020	72 hours efter deeth with the Marylar "naturel", or Nems 23s or 28s-f show ideal Examiner must be notified at	by	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒Divorced	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Yeer or Detes:	0		cedent of Hoecify Cube	Ispanic Ori in, Mexicer Specify:	gin? (Specify n, Puerto Rica	Yes or No- an, etc.)	14. Rac Bla Specif	ce - America ck, White, e y: Wh	
5-0	72 h netu deal	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		Decedent's U (Give kind of	work done	durina mosi	t of working		16b. Kind of B	usiness/Ind	ustry
121	within ene. than one	ign	Elementery/Secondary (0-12)	College (1-4or 5-	+)	life. DO NO	use retired	1)					
12	TO TO be		12		l Fo	reman					Printi		
anc	D D D	Be	17. Fether's Name (First, Middle, Last								Maiden Suman	ne)	
Y	should be ind Mentel imarked c	မ	Alton Leonard 1								Roche		
, Maryland	nd 2 salith er 27 is r treu		James V. Rushing		sa	me as	10 ab		er or Rural Ro	oute Numbe	r, City or Town,	, Stete, Zip	Code)
Baltimore,	of of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special		20b. Place of l come tery Metrop	, crematory o	r other pled	atory			20c. Location		
Balt	permit. Pag Depertment Important: I any Injury once.		21. Signature of Funeral Service Lips	20 A				ss of Facilit neral		Owin	gs, MD	2073	36
	Physician /Medical Examiner		Pert1. Enter the disease, or comshock, or heart failure. List only Immediate Ceuse (Final disease or condition resulting in deeth)	polications that cade in one cause on each line	the death. Do no	ot enter the m	ode of dyin	g, such es	cardiac or re	spiretory err	est,		Approximate Interval Between Onset and Death
ox 68760,	n certificate be executed and and use es the buriel-transit	n/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest	Ser	Struck Oue to (or as a co Oue to (or as a co Oue to (or as a co	onsequence of	sle repe	ep lera 1el	gy 200	ned lasc	. D:	s ,	
.O. Bo	that the deeth ce ned by the ettendi	Physician	Part II. Other significent conditions of	contributing to death bu	t not resulting in	the underlyin	g ceuse give	en in Pert I.			The second second		the cause of death?
Ω.	res that iigned b be deta	by Pi	Mortend	Obes	ely					1 ⊔ Y	es 2LTNo	3∐ Prob	ably 4 Unknown
Records,	aw requi	Completed b			_			·		24a. Wes e perfor	en eutopsy med?	eve	re eutopsy findings ileble prior to apletion of ceuse eeth?
	0 - 0	P							Į.	1 🗆 Y	es 2 HO	1 0	Yes 2 No
Vital	ician: The	Be	25. Was cese referred to medical					26. Place	of Deeth (C	heck only or	ne)	1	
of V	Physician: this certific	၉	examiner? 1 Tyes 2 No	Hospitel: 1   Inpatier	nt 2 ER/Outp	petient 3	DOA Oth	er: 4□ Nu	rsing Home	5 - Restde	ence 6 Oth	er (Specify	)
	ter th		27. Manner of Death 1 ☐ Miliural 5 ☐ Pending	28a. Dete of Injury (Month, Dey	Year) 28b. Tir	me of ury	28c. Injun Worl	/ et </td <td>28d.</td> <td>Describe h</td> <td>ow injury occur</td> <td>red</td> <td></td>	28d.	Describe h	ow injury occur	red	
Division	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	6 00- Dissertists		М	1 🗆	Yes 2□I		Location (Si City or Town		ber or Rurai	Route Number,
	To the Hospital within 24 hours of To the Funeral I completely filled	edical C	29a. Certifier Check any and Medicat Exam	ysicien: To the best of niner: On the basis of e	examinetion end/	death occurre for investigati	od et the tim on, in my op	ne, dete end pinion, deal	d place, and th occurred a	due to the ca t the time, d	ause(s) end me late and plece,	enner es ste end due to	eted. the ceuse(s)
	To the vithing to the company of the	W	29b. Signature and title of certifier	(De)	_		9c. License	number	8	2	9d. Date signe	d (Month, E	Dey, Yeer)
5	1 VA		30. Name end eddress of person who Dr. Rafik				O Fr	eder	ick,M	in 2	0679	- 8 &	
	Sta Registr		31. Dete filed (Month, Day, Year)  JUN 2	32. Registrar	s Signature		-	euel	ICKI	. Z	0076		



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State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Date of Daath **Physician** Month Yaar 105EPH 26 1997 4c. County of Death 3:30 AM JUNG /Medical 4a. Facility Name (If not institution, giva straat and numbar) 4b. City, Town, or Location of Daath Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year)
Months Days Hours Min. March 9, 1945 5. Social Security Numbar 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Country) Maryland **Funeral** 1 M 2 F Yrs. Director 212-54-5387 52 Usual Rasidence of Daceden the Marylend 10a, Stata 10b. County 10c. City, Town or Locetion 10d. Insida City Limits 28a-f ahow r than "natural", or items 23a or 28a-f ahov the Medical Examiner must be notified at 1 Yas 2 No Directo Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 20650 General Delivery United States Funeral death 12. Was Dacedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 █ No 11. Maritai Status Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Race - American Indian, Black, White, atc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
nt: If Item 27 is marked other than "natural", or ite may or other traumatic event, Ite Mental Entities in yor other traumatic event, Ite Mental Entities. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ■ No Specify: λq Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working life. DO NOT usa retired) Elemantary/Secondary (0-12) Collage (1-4or 5+) Food Service Restaurant 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Be Mary Nina Heard Bernard Woodley Ridgell 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code Joseph E. Ridgell, Son 23980 McIntosh Road, Hollywood, Maryland 20636 20b. Place of Disposition (Nama of cemetery, cramatory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ■ Bunal 2 □ Cramation 3 □ Removal from Stata permit. Page Department of Important: If any injury or once. Our Lady's Cemetery 6/30/97 Leonardtown, Maryland 5 Other (Specify) 4 Donation 21. Sign 22. Nama end Addrass of Fecility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 Brinsfield, Jr. M00052 Edward N. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarvel Between Onsat and Daath **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) a Hente Constroratestinal Hemorrhuse Examiner Physician/Medical Examiner Multi-system Organ The law requires that the death certificate be executed the burial-transit Saquantially list conditions, if any, laading to Immadiata ceusa. Entar Undarlying Causa (Disease or Injury that initieted avants resulting in daath) Lest Division of Vital Records, P.O. Box 68760. BUNIST Artern COYONAVA for use es Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contribute to the cause of death? signed by 12 Yas 2 No 3 Probably 4 Unknown Pseudomembranens enterocolitis þ pege 2 should be Completed 24a. Was an eutopsy performed? 24b. Wera autopsy findings available prior to complation of ceuse of death? certificate hes xas 2□ No or Attanding Physician: Be 25. Was cesa refarrad to medicel axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Yas 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this To the Hospital or Attanding Phy within 24 hours efter death. To the Funeral Diractor: After this completely filled in by the funeral: 27. Mannar of Death Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 2 Accidant 5 Panding invastigation Injury 6 Could not be 3 Suicide 28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 28f. Location (Streat end Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homicide 1 Certifying Physician: To tha bast of my knowledge, death occurred at tha time, data and place, and dua to tha causa(s) and menner as steted.

2 Medical Examiner: On tha basis of examination and/or invastigation, in my opinion, daath occurred at tha time, data and place, and dua to the cause(s) and manner stated. 29a. Certifier 29b. Signetura and title of certifiar 29c. Licansa number Hyatsville MD 20782 Sound 6525

32 Tegistrar's Signature

DHMH 16 Rev 6/95

State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Physician May 31, 1997 Betty Virgie Russell 10:00 AM /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Lexington Park 21712 Kearsarge Place St. Mary's | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Pay, 1923) | Hours | Min. | August | 9, 1923 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (Stete or Foreign **Funeral** Months 1 □ M 2 F Virginia 225-24-3482 73 Yrs. Director Usual Rasidance of Decedan permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylend Department of Heelth end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Maritimal 10e. Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 ■ No Directo Maryland St. Mary's Lexington Park 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? 21712 Kearsarge Place 20653 United States 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 12. Was Decedant Evar in U,S. Armed Forcas? 14. Race - American Indien. 11. Marital Stetus Biack, Whita, atc. 1 ☐ Yes 2 ■ No If Yas, Giva 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White þ 3 ■ Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona duning most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife N/A 17. Fether's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maidan Surnama) Be Hansford Coffey Sara Eliza Huff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, State, Zip Code) 44674 Boxwood Drive, Callaway, Maryland 20620 Martin B. Russell 20b. Piece of Disposition (Nama of cematary, cramatory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ■ Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Immaculate Heart of Mary 6/3/97 Lexington Park, MD Funeral Se 22. Nama end Addrass of Fecility 23a. Part1. Enter tha disaasa, or complications that caused the daeth. Do not antar tha moda of dying, such as cardiec or respiretory errest, shock, or haar failura. List only on a cause on aech lina. Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650 Approximata Intervei Between Onset and Death Physician Probable Myo CHEDIAL INFARETION /Medical Immediate Ceuse (Final disaasa or condition resulting in daath) Examiner ate has been signed by the attending physician and page 2 should be deteched for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Diseasa or Injury that Initieted evants rasulting In daath) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consaguance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ð 24b. Wara autopsy findings evellable prior to complation of cause of death? 24e. Wes en eutopsy performed? Completed certificate Attending Physician: 25. Was casa rafarred to medical Be 28. Place of Death (Check only one) axaminar? 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 3 DOA 10 1 ☐ Inpatiant 2 ☐ ER/Outpatient this funeral 27. Manner of Death 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) Certification: 28b. Time of 28d. Dascribe how injury occurred After Injury 5 Pending Investigation To the Hospital or Attending within 24 hours effer death.
To the Funeral Director: Afte completely filled in by the fun. 1 Yas 2 No 2 Accidant 3 Suicida 6 Could not ba 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 I Homicida 15) Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

2 Medicat Examiner: On tha basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and place, and dua to tha causa(s) end mennar stated. 29a. Certifian Medical (Check only one) 29c. Licansa number 29d. Dete signed (Month, Dey, Year) 29b. Signature and titla of certifier 6-3-97 D14582 30. Nama and addrass of person who complated cause of daath (Item 23a) (Type, Print) William D. Boyd II, Leonardtown, Maryland 20650 M.D.

32. Ragistrar's Signatura

State Registrar

31. Dete filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 3

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Courth Month Yeer **Physician** VERA FRANCES RICHARDSON 10:15 AM 10 1997 June /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner St. Mary's Nursing Center Leonardtown St. Mary's 5. Sociel Security Number If Under 1 Yeer | If Under 24 Hrs. Birthplece (State or Foreign Country)
 MD 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthdey) **Funeral** 1 □ M 2 F Months Deys Hours Yrs. 220-32-7034 94 1902 Director August 11, Usuel Residence of Decedent filed within 72 hours efter death with the Meryland 10e Stete 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 ₹ No St. Mary Leonardtown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 42520 Riverwinds Drive 20650 USA 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2K No Specify: Specify: White à 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Pages 1 end 2 should be filed within nent of Health end Mental Hygiene. Int: If Item 27 is marked other then ' Irry or other traumatic event, the Me Elementery/Secondery (0-12) College (1-4or 5+) Owner Operator Antique Shop 17. Fether's Neme (First Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Samuel Porter Cropper Sarah Martha Gault ည 19e. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42520 Riverwinds Drive, Leonardtown, MD 20650 as of Disposition (Name of Date 20c. Location - City or Town, State Leroy Roger Richardson, Jr./Son 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Department of Important: If I any Injury or Once. Injury or St. Paul's Methodist Cemetery 6/14/97 4 ☐ Donetion, 5 ☐ Other (Specify) Leonardtown, MD 21. Signature of Funerel Service Lictins 22. Neme end Address of Fecility.
Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 23a. Pert1. Enter the deese, or complication, that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical Immediate Cause From diseese or condition resulting in death) Examiner Examiner that the death certificete be executed physician end s the buriel-trans Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): 80 use ţō deteched Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 1 Probably 4 Unknown þ 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed has 1 Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Norsing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending Investigation Netural 2 Accident deeth. 1 ☐ Yes 2 ☐ No or Attend efter deeth Director: / 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide filled in by 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours of To the Funeral Di completaly filled is Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner as steted.

Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) and menner steted. Medical 29a. Certifier (Check only 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) **B25230** June 11, 1997 30. Name end eddress of person who completed a up of deeth (Item 23e) (Type, Print) 2050 Wilde wood Con, Calif, MD 20619 Dr. David C. Allen

State

Registrar

31. Dete filed (Month, Dey, Year)

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32. Registrar's Signeture

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Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Date of Daath 3. Time of Death **Physician** Month SICHARD James 35 pm June 1997 /Medical 4e. Facility Nama (If not institution, giva straat and numbar) 4b. City, Town, or Location of Death 4c. County of Daath Examiner Washington Adventist Hospital Tokoma Park Montgomery 5. Social Sacurity Number If Under 1 Yaar If Under 24 Hrs. 9. Birthplaca (Stata or Foreign South Carolina 7. Aga (In yrs. lest birthday) 8. Data of Birth (Month, Day, Yaar) **Funeral** Months Days 1 XM 2□ F Hours Director 83 Yrs. 247-14-2662 Nay 19, 1914 Usual Rasidance of Decedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits Peges 1 end 2 should be filed within 72 hours efter death with the Marylan nent of Health end Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f ahow ury or other traumatic event, it a Madical Examinal must be not the different and the collections. Director 1 AYas 2 No District of COlumbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20001 Funeral 1616 Marion Street N.W. United States Was Decedent Evar in U,S. Armad Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, White, etc. I ☐ Yas 2 ☒No If Yas, Giva Year or Datas: 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: Black Completed by 1 ☐ Yas 2 TNo 3 ☑ Widowad 4 ☐ Divorced 16a. Dacedant's Usuel Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Painter Construction 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Surnama) Be James Robinson Mary Jamison Robinson 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Peges 1 end 2 s
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Important: if item 27 is
any injury or other trau Corinne Hairston 2424 Portage Road; Silver Spring, Maryland 20906 20b. Placa of Disposition (Nama of camatery, cramatory or other pleca) June 19, 1997 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Spacify) Gate of Heaven Silver Spring, Maryland 22. Nama and Address of Facility Latney's Funeral Home, Inc. 21. Signature of Funeral Service License Bara 3831 Georgia Avenue N.W.; Washington, DC 20011 rollenon 23a. Part Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Physician Immadiata Causa (Final diseesa or condition resulting in death) /Medical Examiner ettending physician end for use es the bunel-trensit or Attending Physician: The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Diseasa or Injury thet initiated avants rasulting in daeth) Last P.O. Box 68760, Physician/Medicai Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 ☐ Unknown Division of Vital Records, þ pege 2 should be Completed 24b. Wara eutopsy findings eveilabla prior to complation of causa of deeth? 24e. Wes en autopsy performed? After this certificete 2 No 1 Tas 1 ☐ Yas 2 ☐ No Be 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Check only ona) 2 1 Yas 2 No Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA s efter death.

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2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end mannar stated. 29a. Cartifiar Medical (Check only 29b. Signature and tibe of certifier 29c. Licansa number June, 13 30. Nema and addrass of person who complated cause of death (Item 23a) (Typa, Print) ERRY STREET, MT. RAINIER. MD20712 3503 F 31. Deta filed (Month, Day, Year) 32 Registrar's Signetura State **JUN 27** Registrar

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State of Maryland / Department of Health and Mental Hygiene

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a			25. Was casa referred to medical							1 🗆	/	11	Yes 2□No	)
Vital		o Be	axaminer?	Hospital:			·	ther.		(Check only				
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on	Attanding Phor death. sector: After the by the funeral	tion	1 Naturel 5 ☐ Panding	28a. Date of Inju (Month, Da)	Yeer)	Injury	28c. In W	ork? □Yes 2□		Lou. Dudonibo	now injury occu			
S	Attandi er death ector: A by the f	lica	3 ☐ Suicide 6 ☐ Could not be		inv - At home fo	arm etre				28f Location /	Street end Num	her or Rure	I Poute Numbe	
Division	3 4 5 5	Certification:	4 ☐ Homicide detarmined	building, etc	. (Specify)	ziiii, Sile	et, factory, offic	0	1	City or To	wn, State)	ber or nure	n noute ivanibe	,
	pours ours eral		29a. Certifiar 1□ Certifying Phy	relaten: To the bast	of my knowledge	donth	annurred at the	time data ar	d alass	and due to the				
	24 h 24 h Fun etely	edicai		rsician: To the best of iner: On the bests of and manner ste	examination en	nd/or Inv	estigation, in m	opinion, dea	th occurr	ed et the time,	date end place	enner as s , end due to	the ceuse(s)	
	To the Hospital or within 24 hours efter To the Funeral Dir completely filled in	Me	29b. Signeture end title of certifier	and mariner ste		1	29c. Lica	nse number			29d. Date sign	ed (Month	Dev. Year)	
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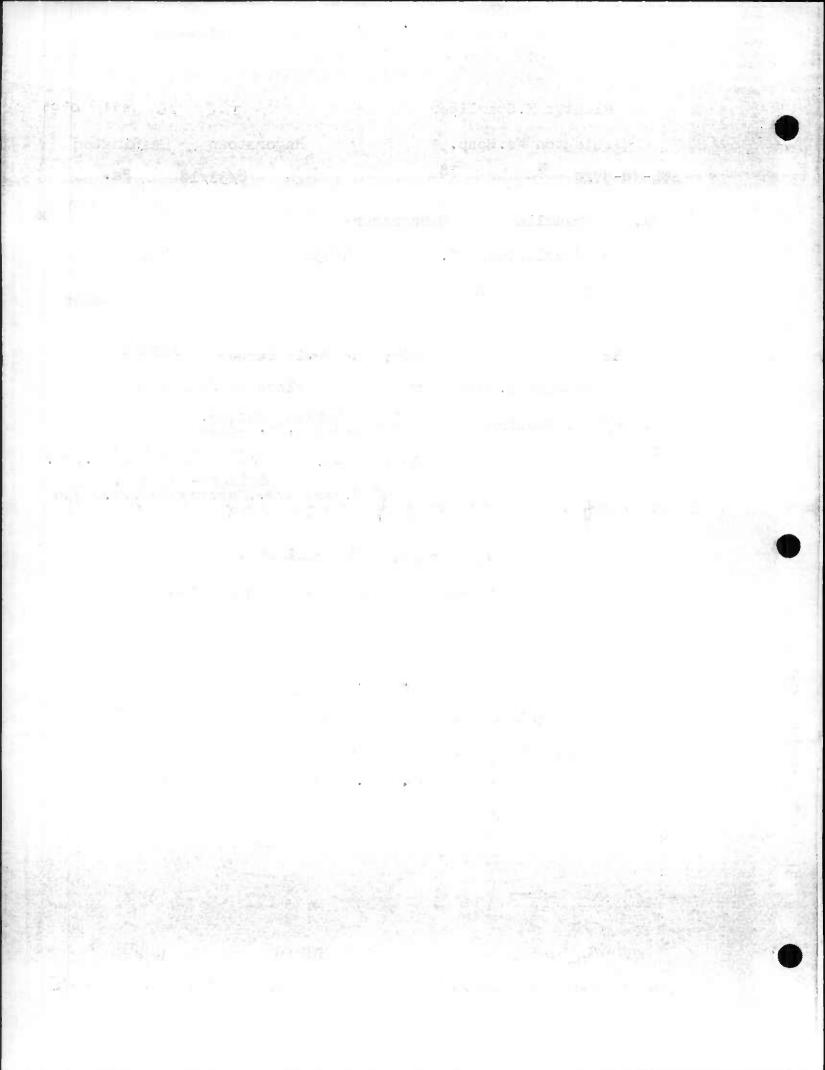
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 0 4

					Cei	tificate d	of Death	,	Reg. No.		
	Physic	ian	1. Decedent's Name (First, Middle, Last,	)				2. Date of Dec	eth	Yeer	3. Time of Deeth
	Physici /Medi		Ruth Richar	rdson				June			8:15 A
	Exami		4a. Fecility Neme (If not institution, give	street end number)			4b. City, Town, or				
			Pine View Nursing				Clinton		Prince	e Gec	orges
ı	Funeral		5. Sociel Security Number 6. Sec	TM 2□F	last birthday) Yrs.	if Under 1 Ye Months De		. (Month, De	v, Year)	9. Birthpia Count	ace (State or Foreign ry)
L	Director		Usual Residence of Decedent	X 90	115.			July 6	,1906	New_	Jersey
	land		10a. Stete 10b. County	10c. City	y, Town or Lo	cation				10	d. Inside City Limits
	Mary Feb	to	Maryland Prince	Geroge's	Clint	on					1 □ Yes 2√ No
	n 72 hours efter death with the Maryland "natural", or items 23a or 28a-f show sitcal Examiner must be notified at	ai Director	10e. Street end Number Pineview Manor	Nursing Ho	me	10f. Zip Cod 2073			10g. Citizen of W United		
	dea	Funerai	11. Marital Status	12. Was Decedent Ever in U, Armed Forces?	S. 13. V	Vas Decedent	of Hispenic Origin? (S Juban, Mexican, Puer	Specify Yes or No-		- America	
Maryland 21215-0020	ours efter ral', or its	þ	1 Never Married 2 Married 3 XWidowed 4 Divorcad	1 ☐ Yes 2 💥 🎁 If Yes, Give Year or Dates:		☐ Yes 2)X		to nican, etc.)	Specify:	k, White, et W]	hite
5-0	thin 72 ho e. en "netur	Completed	15. Decedent's Edu (Specify only highest grede	cation e completed)	16a. Deced	ent's Usuel Oc	cupetion	rkina	16b. Kind of Bus	siness/Indu	ustry
21	E . E	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	O NOT use re	ne during most of wo tired)	rking			
2	DO	ပ္ပိ	8th		Tele	phone	Operator		AT&T		
anc	a la b	Be	17. Fether's Neme (First, Middle, Lest)	1.				me (First, Middle,		1)	
Z	should be nd Mental marked o	P	Robert W. Call		T			Schoun			-211-2
Ma	2000		19e. Informent's Name/Reletionship (Ty) Helen Grisson	pe, Print)			eetend Numberor R Street, S				
ď	of Health Item 27 other tr		20e. Method of Disposition	20b. P				Date Die	20c. Location - C		
altimore,	Pages nent of the int: If Ite		1 ☐ Bunai 2 ☑ Cremetion 3 ☐ R	remover nom State		sition (Neme of netory or other					
二	ift. Partme		4 ☐ Donation 5 ☐ Other (Specify)  21. Signeture of Funerei Service Licanse		Crem	atory	June 17	, 1997	Clintor	ı,Ma:	ryland
Ba	permit. Pages 'Depertment of F Important: if the any injury or of		15t 8.5jt		01	d Alex	dress of Fedilit <b>L</b> ed Kandria I	e runer Ferry R	al Home	into	c 6633 on,Md
	Physician	i F	23a. Pert1. Enter the disease, or compil shock, or heart failure. List only or	5740						1	Approximate Intervel Between Onset end Deeth
	/Medical		Immediete Cause (Finei disease or condition	ACUTE	My	OCAR!	DIAL -	LNFAR	CTION	0	WE DAY
П	Examiner		resulting in death) e		r es e conseq						
-	D #	iner									
	certificate be executed rding physician and use es the buriel-trensit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	Due to (or	es e conseq	uence of):					
60,	be e) clan burie		Cause (Diseese or injury								
68760,	phys phys the	edicai	thet Initieted events resulting in death) Last	Due to (or	es e consequ	ienca of):					
	ding se es	5		J							
Box	that the death cer hed by the attendir deteched for use	Physician/I	Date Office Indiana								
P.O.	the d	nysi	Pert II. Other significant conditions con	tributing to deeth but not resu	ilting in the un	derlying cause	given In Pert I.				the cause of death?
	thet bed b							101	es 2 No	3 Probe	ably 4 🖾 Unknown
Division of Vital Records,	law requires thet the es been signed by th 2 should be detech	d ba						24a. Wes	an eutopsy	24b. Wer	e eutopsy findings
00	w rec	Completed						perfor	med?	com	lebie prior to pletion of ceuse eeth?
æ	The lav	E						400	- OFA		
ta	certificate rector, pe	Be C	25. Wes case referred to medical				De Diago of Da	eth (Check only o	es 2 M/No	10	Yes 2□ No
>	Physician: The introduction of the formula director, pege	ToB	evaminer?	ospitei:	ER/Outpetient	3□ DOA	Other:	lome 5 ☐ Resid		(Canaihi)	
ō	er thi		27. Manner of Death	28e. Dete of injury (Month, Dey Yeer)	28b. Time of	28c. Ir		T	ow injury occurre		
Ö	ndin eth. r: Att	atio	1 X Neturel 5 ☐ Pending investigation	(Month, Dey 1661)	Injury		Yes 2 No				
<u>×</u>	er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - At hor building, etc. (Specify	me, farm, stre	et, fectory, offic	De .	28f. Location (S City or Tow	treet end Number	r or Rural I	Route Number,
<u></u>	rs eft ai Di	Cer		banding, sto. (opeon)	,			Oily or Tow	., 0.0.0)		
	To the Hospital or Attending Pr within 24 hours eiter death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier 1 ☐ Certifying Phys (Check only 2 ☐ Medical Examin	Ician: To the best of my know er: On the basis of examinati	viedge, deeth	occurred et the	time, date end plece	, end due to the c	ause(s) end men	ner es ste	ted.
	the the the riplet	Med	0.10)	and manner stated.	0110110011111						
	So J with	Σ	29b. Signature and title of certifie	Mar Mil	)	29c. Lie	nse augriber 55	23 1	29d. Date signed	Month D	ay. Year)
			MAN INN	1 milli	,	5			0	1	1
			30. Neme and eddress of person who con	npleted cause of deeth (Item	23e) (Type, F	rint)					
			John Van Dam, M.D. 31. Date filed (Month, Day, Year)	3508 Old Sil	ver Hi	ll Rd.	Suitland,	Md.			
	Sta Registra	-	IIII 0 9 100	32. Registrer's Signat	W Ray	11.					

						Certifica	te of	Death	R	eg. No.			
			1. Decedent's Neme (First, Middle, Las	st)					2. Dete of Deet	h		3. Time of De	ath
	Physici /Medi		JAI	MES W.		ROACH	So		JUNE -	29-1	Yeer 997	518	PM
	Exami		4e. Fecility Name (If not institution, give			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	4b. City, Town, or L		4c. County			
			Southern 1	MARY IMNO	پ	Landinal		Ch.	(70.0)	Par	NCL-	Boul	100
۳	Funeral		Sociel Security Number     6. Security Number		In yrs. lest bi		er 1 Year		8. Date of Birth			ece (State or Fo	oreign
п	Director		228-36-2714	M 2□F 68		Yrs. Months	Deys	Hours Min.	June 12	2,1929	Coun	lece (State or Fo try) rginia	
	ō.		Usuel Residence of Decedent										
	how		10e. State 10b. County		•	m or Location					16	0d. Inside City L	
	e-f-s	ç	Maryland Prince G	eorge's	Clin	nton						1 □ Yes 2	□ No
	th th	Director	10e. Street end Number			10f. Z	ip Code		1	0g. Citizen of V	Vhef Coun	try?	
	th wi	ai	7619 Poplar Hill	Lane		20	735			U.S.	A.		
	eep dee	Funeral	11. Merital Stetus	12. Was Decedent Eve Armed Forces?		13. Was Deci	edent of I	Hispanic Origin? (Spen, Mexicen, Puerto	pecify Yes or No-		e - America		
0	or its	显	1 Never Married 2 Married	1 X Yes 2 No		1 Tes, sp			nican, etc.)		k, White, e . Whi		
00	hours efter deeth with the Marylend turel, or items 23a or 28a-f show at Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Dates: 19	953	1 Yes	2 KJ- NO	Specify:		Specify	: AATIT	.LE	
21215-0020	n 72 hours efter deeth with the Marylen "naturel", or items 23a or 28a-f showed cal Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucetion	16a	Decedent's Usi	uel Occup	petion	kina	16b. Kind of Bu	siness/Ind	lustry	
21		D S	Elementary/Secondery (0-12)	College, (1-4or 5+)				during most of work d)	(III)				
2	77 5 1 5	ဝိ	6	N/A		Receivir	ng Cl	erk		Food	Store	<u>}</u>	
pu	0 0 0	Be	17. Fether's Neme (First, Middle, Last)	<b>.</b>					e (First, Middle, I		•		
yla		2	(Unknown)	Roach				Ell:	ie	Edward	S		
Maryland	d 2 should thend Mer 7 is market treumatic	ļ.,	19e. Informent's Name/Relationship (7		198	. Mailing Addres	s (Street	end Number or Ru	ral Route Number	City or Town,	Stete, Zip	Code)	
			Mary Anne Roach	(MTTG)		/619 PC	ртаг	Hill Lar	ne Clinto	on, Mar	yrano	1 20/35	
Baltimore,			20a. Method of Disposition  1 → Burial 2 → Cremation 3 →		20b. Plece o cemete	f Disposition (Ne	me of other pla	July	3 Dete	20c. Location -	City or To	wn, Stete	
Ĕ	Pages nent of I int: if its iry or o		4 Donetion 5 Other (Specify		Resur	rection	Ceme	etery	1997 (	Clinton	, Mar	yland	
alt	permit. Pages Depertment of Important: if it any injury or once.		21. Signature of Funeral Service License	1 /				ess of Fecility Le					
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	_		23a. Part 1. Enter the classics, or comp shock, or heart feilure. List only of	ilications that ceused the	e deeth. Do	not enter the mo	de of dyi	ng, such es cardiac	or respiretory erro	20735		Approximete	
7	Physician		Snock, or near tellure. List only o	one ceuse on eech line.		,					į	Onset end Deet	n th
4	/Medical		Immediete Cause (Final	C	and	ica	/	DALITA	, p		İ		
ŀ	Examiner		disease or condition resulting in deeth)	e	e to (or es e	consequence of	· ·	- Deg 70					
Ш		Je.		CI,		2 44-	0	Taxe.	die	وسعد	[		
	cuted nd rensi	Examiner	Sequentially list conditions	b. — Du	e to (or es e	consequence of	1:	7	0	7			
ó	an er		Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury	ST	T	· 10-40	+ 1	N- 41.	V mm	w. he	م ام الاس		
68760,	certificate be executed rding physician end use es the burial-trensit	edicai	thet initiated events	C. Du	e to (or es e	consequence of)	7 .	you	1 dech	7-11			
	E 000	Med	resulting in deeth) Lest		(	,		0 /	-9-1	7			
Вох				d									
<u> </u>	tha daeth by the atter ached for	Physician/	Pert II. Other eignificant conditions co	onfributing to death but n	not resulting l	n fhe underlying	ceuse di	ven in Pert i	23h Did to	bacco uee con	atribute to	the cause of de	eath?
P.O.	t tha by th tache	hy		3								ably 4 D tink	
	s that med b	by P							,	20110			
Ď	requiras veen sign hould be	9							24e. Wes e	n eutopsy		ore eutopsy findia	ngs
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	e	Completed							1 D V	s 2 No		Yes 2□ No	
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>	Physicien: r this certific ral director,	To B	exeminer?	Hospital: 1 ☐ Inpatienf	2 DERVOL	utpatient 3□ D	OA Ott	nor:	th <i>(Check only on</i> ome 5 ☐ Reside		ar (Canaik	٠,	
ō	Phy r this eral c	] <u>-</u>	27. Menner of Death	28e. Date of Injury (Month, Dey Yo		-	28c. Inju Wo		28d. Describe ho			)	
S D	dlng th. Afte	tion	1∠Neturel 5 Pending 2 Accident investigation		ear) I	njury M		rk?  Yes 2∐No					
Division	Attending in death.  Sctor: After by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be		- At home, fa				28f. Location (St	reet end Numbe	er or Rure	Route Number.	
	or A eftar Direct	er	4 ☐ Homicide determined	building, etc. (3	Specify)	,,,	,,		City or Town			,	
	To the Hospital or Attending Physicien: within 24 hours effar death. To the Funerel Director: After this certific complately filled in by the funeral director.		29a. Certifier 1 Certifying Phy	reician: To the best of m	ny knowledne	, deeth occurrer	l et the ti	me, dete end place	end due to the co	ouse(s) and ma	nner es et	eted.	
	24 h Fur ately	edicai	(Check only 2 Medical Exami	Iner: On the basis of ex	amination en	d/or investigation	n, in my	ppinion, deeth occur	red et the time, da	ate end piece, e	and due to	the cause(s)	
	To the within 2 To the complain	Me	29b. Signature end title of certifier			29	c. Licens	se number	2	9d. Dete signed	d (Month, I	Day, Year)	
	->-0		) 79_ D	Boles.	7		·	. 3		6-20	1/00	-	
			30. Name and address of person who a	ompleted course of dark	h (Hom 22c)	(Tuno Print)	וטע	+ 358		6-30			
			30. Neme end eddress of person who co	Graphered cause of death	6 5 4	(1 ype, Print)	01	4358	11	20	272	16000 1	M
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrer's		7/100	16	SIS FINE	Up	Ner //	lend	0000	TLD
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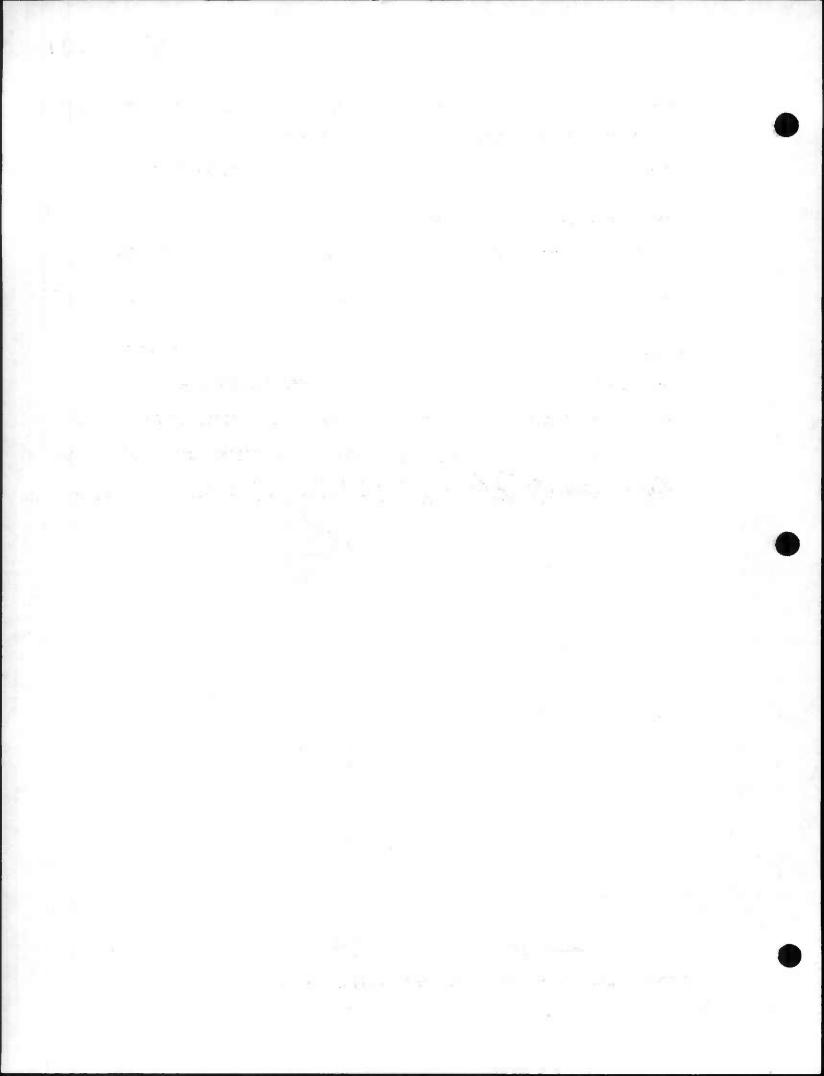
ellis.o per	· Fh	,23b per MD G-750 8/1			Certificate of			g. No.		
Physicia	an	Decedent's Neme (First, Middle, La					<ol><li>Deta of Death Month</li></ol>	Dey	Yeer	3. Time of Death
/Medic			M.Starl	iper			June	26 1	Yeer 997	0909
Examin	er	4e. Fecility Neme (If not institution, given				4b. City, Town, or Loca	ation of Deeth	4c. County of	of Deeth	
		Washingto		p.		Hagers	town	Wash	ingt	ton
Funeral			Sex 7. Age 12≦M 2□F	(In yrs. last bir	Months Dev	ar If Under 24 Hrs.	3. Date of Birth (Month, Dey,	8/21/18 Yeer)	9. Birthple	ece (Stete or Foreig
Director		204-30-5920	TESTVI ZUF	78	Yrs.		3/31/1	8	Pa.	
p .		Usuel Residence of Decedent  10e. Stete 10b. County		10c. City, Town	or Location				10	
anyla sho	_		-3 •						10	<ul><li>d. Inside City Limits</li><li>1 ☐ Yes 2 No.</li></ul>
Ba-1	cto	Pa. Frank	clin	Merc	ersburg					ILI Yes 2404 No
it t	5	10e. Street end Number			10f. Zip Code		10	g. Citizen of W	het Countr	γ?
23a	a	6963 Chai	rlestown	Rd.	177	236		USA		
ep .	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	var in U,S.	13. Was Decedent of	f Hispenic Orlgin? (Spec Jben, Mexican, Puerto R	ify Yes or No- ican, etc.)		- Amarica	
permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be instilled at once.	þ	1 ☐ Navar Married 2 ☐ Married 3 ☐ Widowad 4 ☐ Divorcad	1 Yes 2 N If Yes, Give Yaar or Dates:	0	1 ☐ Yes 2 🖾 N		, , , ,	Specify:		nite
2 ho	De le	15. Decedent's E	ducation	16a.	Decedent's Usuel Occ	upation	10	6b. Kind of Bus	siness/Indu	ustry
hin 7	Be Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) Coltege (1-4or 5		(Give kirid of work don life. DO NOT use retii	upation re during most of working red)	7			
d wit	E 0	12	College (1-4015		iry and 1	Fruit Far	ner	Farmi	ng	
othe	9	17. Father's Name (First, Middle, Last	)			18. Mothar's Nama		a <i>iden Sum</i> ema	a)	
enta ked ked	To B	Char	Les M.Sta	rliper	•	Floren	ce Pen	singer		
Shou mar mar	-	19e. Informant's Name/Reletionship (	Type, Print)	19b	Mailing Addrass (Stre					Code)
nd 2 Ith ar 17 is		Mrs.Cecyl M.St			6963 Ch	at end Number or Rural arles Two: ourg. Pa.	Rd.			,
Hea Hea		20a. Method of Disposition	our Empor	20b. Placa of	Disposition (Name of y, crematory or other p	ourg, ra.	Date _ 20	Oc. Location - C	City or Tow	m. Stata
ages ant of t: If III		1 ☐ Burial 2 ☐ Cremetion 3 ☐			y, crematory or other p.		29 H	oc. Location - Cercers rankli	burg	Pa.
rtm rtan		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Selvica Mcar		1.977						
Deper Impo		21. Signature of Furieral Servica vical	timin	PU	47 N.Pa	ress of Fecility Liniark Ave., l	inger-l	sburg.	Pa.l	7236
		23a. Part1. Entar tha diseese, or com shock, or heart failure. List only	plications thet caused	tha daath. Do r	ot enter the mode of d	ying, such as cardiac or	raspiratory arres	st,		Approximata Intervel Between
/Medical Examiner  B bhysician and es the burial-trensit	Examiner	Immediate Ceuse (Final disease or condition resulting in death)  Sequentially list conditions	b. Post	ope-et.	consequence of):	Infection		~~		
e exe	Ω	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							1	
ysic he b	edicai	that initiated events resulting in deeth) Lest	C	Due to (or as a c	onsequenca of):					
ng ph	<b>SE</b>	Tooling III doodily 2001							1	
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dea e ett	Physician/	Part II. Other eignificant conditions of	ontributing to death bu	t not resulting in	the underlying cause of	given in Pert I.	23b. Did tob	acco use conf	tribute to	the cauea of deat
by th	ب	. \					1 ☐ Yes			ably- 4 □ Unkno
ned e de	by F	Insula	depudent	duchel	es millip	3			34	,
w requires that the death certification is been signed by the ettending should be detached for use es	Completed	History	of Hym	hasion,	ce-quitire	heart feiler	24a. Was en performe		avai	e eutopsy findings lable prior to pletion of cause eath?
ne la	E		and 0-40		y occardial.	( )	400	2 X No		
sician: The law certificete hes b irector, page 2 s	Ö	OF Was asso referred to madical	110 113		Lacorarel .		1 ☐ Yes		- 1	Yes 2□ No
8 F #	<b>m</b>	25. Was case referred to medical examiner?	Hospital:			26. Place of Deeth				
lole cer	<u>د</u>	1 XYes 2 No 27. Menner of Death	1 Einpatier		patient 3 DOA	4   Nursing From	e 5 ☐ Residen d. Describe how			
Physici r this cer		1 Natural 5 ☐ Pending	28e. Date of Injur (Month, Dey	Year) In	njury W	ork? □ Yes 2 □ No	S SSON NO TIOP	occurre		
ding Physici h. After this cer funeral direc	ţ	Z II Noolderit		nr. At home for			f. Location (Stre	act and Numba	r or Pum!	Route Number
trending Physical death.	ication	3 ☐ Suicide 6 ☐ Could not b	building, etc	(Specify)	rm, street, factory, office	α 20	City or Town,		or riurer	LIOUTE (AUTHOR)
al al a	rtification	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined								
pital or Attending Physici urs after death. vrai Diractor: After this cer iilled in by the funeral direct	I Certification	4 Homicide determined				time, dete end pleca, er	d due to the ceu	use(s) end men	nner es ste	
Hospital or Attending Physici 24 hours after death. Funeral Director: After this cer tely filled in by the funeral direct	Ilcal Certification	4 Homicide determined  29a. Certifier (Check only 2 Madicel Exer	ysician: To the best of	exemination end	death occurred et the Vor investigation, in my	opinion, deeth occurred	et the time, dat	te end place, er	nd due to t	ted. the cause(s)
the Hospital or Attending Physici thin 24 hours after death. the Funeral Director: After this cer mpletely filled in by the funeral direct	ledical Certification	4 Homicide determined  29a. Certifier (Check only one)  1 Cartifying Ph 2 Madical Example 1	ysician: To the best of niner: On the besis of end manner sta	exemination end	Vor investigation, in my	opinion, deeth occurred				the cause(s)
ne Hospital or n 24 hours after ne Funeral Dir pletely filled in	-	4 Homicide determined  29a. Certifier (Check only 2 Madical Exar	niner: On the besis of	exemination end	Vor investigation, in my	opinion, deeth occurred		d. Date signed		the cause(s)
To the Hospital or Attending Physici within 24 hours after death.  To the Funeral Director: After this cer completely filled in by the funeral director.	-	4 Homicide determined  29a. Certifier (Check only one)  1 Cartifying Ph 2 Madical Example 1	niner: On the besis of	exemination end	Vor investigation, in my	opinion, deeth occurred				the cause(s)
To the Hospital or Attending Physici within 24 hours after death.  To the Funeral Director: After this cer completely filled in by the funeral director.	Σ	4 Homicide determined  29a. Certifier (Check only one)  1 Cartifying Ph 2 Madical Example 1	end manner star	exemination ended.	Vor investigation, in my	nse number	296	d. Date signed	(Month, D	ey, Yeer)
To the Hospital or Attending Physici within 24 hours after death.  To the Funeral Director: After this cer completely filled in by the funeral directors.	Σ	4 Homicide determined  29a. Certifier (Check only one)  1 Cartifying Ph 2 Madical Example Madical Example Address Complete Madical Example Mad	end manner star	exemination end ed.	Vor investigation, in my	nse number  D36764	296		(Month, D	the cause(s)



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 0 7

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Yaar Samuel 1 27, Swann June 8:00 AM 1997 /Medical 4a. Fecility Nama (If not institution, give straat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7620 MARSHALL'S CORNER ROAD CHARLES POMFRET | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | FEB. 25, 1907 5. Social Sacurity Number 6. Sex 1 M 2 F 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** 90 MARYLAND 214-28-3910 Yrs. Director Usual Rasidence of Decedant death with the Maryland 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show the Medical Examiner must be notified at 1 Yas 2 No Director POMFRET MARYLAND CHARLES 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? ŏ 7620 MARSHALL'S CORNER ROAD 20675 UNITED STATES or Items 23a Funeral 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yas, Giva Was Dacedant of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) Rece - American Indian Black, White, etc. filed within 72 hours after 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 Specify: AMERICAN INDIAN 1 ☐ Yas 2 No Specify: þ 3 Widowad 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highast grade complated) 16a. Dacedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry alth and Mental Hygiene. 27 is merked other than "r r treumetic event, the Med Elementery/Secondary (0-12) College (1-4or 5+) 3RD. GRADE **FARMER** FARMING 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumame) Be permit. Peges 1 and 2 should be to Depertment of Health and Mental Important: If Item 27 is marked of any Injury or other traumatic eve JAMES SWANN MAMIE PROCTOR SWANN 19a. Informant's Name/Raiationship (Typa, Print) 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) ERMA THOMPSON / NIECE 8868 SPARROW COURT, BEL ALTON, MARYLAND 20b. Placa of Disposition (Nama of cemetery, cramatory or othar place) 20a. Method of Disposition

1 ☐ Burlal 2 ☐ Cremation 3 ☐ Ramovel from Stata 20c. Location - City or Town, State IGNATIUS CHURCH CEM. 7/1/97 CHAPEL POINT, MARYLAND 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Service License THORNTON FUNERAL HOME, P.A. LYDIA C. THÓRNTON JOHNSON MO0583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximete Intarval Batween **Physician** Onsat and Deeth /Medical Immediata Causa (Finai disaasa or condition rasulting in deeth) asu kayor **Examiner** Dua to (or as a consequence of): Examiner buriel-trensit Attending Physician: The law requires that the death certificete be executed Sequantially list conditions, if any, laading to immadiate cause. Entar Undarlying Ceuse (Disease or injury that Initieted evants rasulting in daath) Lest pue Dua to (or as a consequence of): Records, P.O. Box 68760. physician Physician/Medical the Dua to (or as a consequence of): 98 for use ed by the a deteched f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ pege 2 should be 24b. Ware eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate has 1 ☐ Yes 2 19 No 1 ☐ Yas 2 ☐ No Division of Vital la vous Be 25. Was casa rafarrad to medical axaminar? 26. Placa of Daath (Chack only ope) Other: 4 Nursing Homa 2 1 Yas 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 5 □ Rasidance 6 □ Other (Specify) this spital or Attending Physhours after death.
neral Director: After this y filled in by the funeral di 27. Menner of Death 28e. Data of Injury (Month, Day Year) Medical Certification: 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Panding Invastigation 1 Naturei 1 Yas 2 No 2 Accidant 3 ☐ Suicida 6 Could not be determined 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowladga, death occurred at tha time, date end place, and due to the cause(s) end mannar as steted.
2 Medical Examinar: On the basis of axaminetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifier (Check only one) 29b. Signatura and titla of certifian 29c. License number 29d. Data signed (Month, Day, Year) D-25992 30. Nama and address of person who complated causa of daath (itam 23a) (Typa, Print) Khadar Baig, MD., 6620 Crain Highway, P.O. Box 190, La Plata, Maryland 20646 31. Data filed (Month, Day, Year) 32. Ragistrar's Signetura State whi Stavelson Rardall Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

21108

						Ce	rtificate	e of	Death			Reg. No.				
		Н	1. Decedant's Name (First, Middle, Li	ast)							2. Deta of De	eth		3. Time o	f Death	
Physic /Med			Littleton J. Sterling								Month June 2	Dey 199	Year 7	1.23	p.m.	
	/Medi Examir		4e. Facility Name (If not Institution, git		4b. Ci			4b. City, To	b. City, Town, or Location of Deat					р.ш.		
			Edw.W.McCready Memorial Hospital				Cr			Crisfield			erset			
	Funeral			Sex 7. Age (In yrs.		st birthday)	if Under				8. Deta of Bir (Month, De	th Variable	9. Birthr	lace (State	or Foraign	
ш	Director		163-05-3000 <sup>0⊠ M 2□ F</sup> 88			Yrs. Months Day			Hours Min. (Month, Cotober		October 4	1, 1908	Ma	hplace (State or Foraign untry) arvland		
	Φ .		Usual Residence of Decedent										4			
	nytar show	To Be Completed by Funeral Director	10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City L										ity Limits			
	o Ma		Maryland Somerset Crisfield 1□Yes 2									20 No				
	permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Manyland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, it a Meximal Examinar must be notified at 200ce.		10e. Street end Number				10f. Zip	Code				10g. Citizen o	of Whet Cour	ntry?		
			3486 State Street	;		21817						U	J.S.A.			
e, Maryland 21215-0020			11. Maritel Status	12. Wes Decedent Armed Forces	Ever in U,S.	. 13.	Wes Daced	Dacedent of Hispanic Origin? (Specify Yas or I specify Cuban, Maxican, Puarto Rican, etc.)			ecify Yas or No	- 14. F	leca - Amaric	narican Indien,		
			1 Never Merried 2 Married	1 ☐ Yes 2 😾	1 ☐ Yes 2 ☑ No If Yas, Giva			☐ Yes 2 X No Specify:			, , ,			hite		
			3 XWidowad 4 □ Divorced	Yaer or Dates:								opouny.				
			15. Decedent's E (Specify only highest gr	ducation ade completed)		16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired)					ing	16b. Kind of Business/Industry				
			Elementary/Secondary (0-12)	Collaga (1-4or	5+)	Sales						Cut lory Mea				
			H. S. Graduate  17. Fethar's Neme (First, Middla, Lasi	2 Years							o /First Middle	Cutlery Mfg.				
			Cornelius L. Sterling				Edith 1				le (First, Middla, Meldan Surneme)					
			19e. Intorment's Name/Reletionship (Type, Print)  Jimmie Lee Howard (Step-Son)				19b. Mailing Address (Street end Number or Rural Route Number 8351 Hilda Drive - Salisbury,									
			20e. Method of Disposition	(Step-So	-		sition (Nem		Ive -	Sai	Dete		n - City or To	wm State		
00			1 ☐ Buriel 2 ☐ Cremetion 3 ☐		cen	natary, crer	natory or of	ther ple		6						
Baltimore,			4 Donetion 5 Other (Special Service Lee	7	Sal	#	y Cre				/24/97	SdII	sbury,	MD		
Ba			Solutte B	ladela	1	E	Bradsh	a Addre	ss of Fecilit & Son	s Fu	neral H	<b>Tome</b>				
			Robert H. Bra								Crisfie		218	17		
	Physician /Medical Examiner	er	23a. Pent. Enter the diseasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiretory errest, shock, or heart teilure. List only one cause on each line.  Approximate intervel Between													
			Onset and Deeth													
			Immediate Ceuse (Final disease or condition rasulting in daath)	EPI	10	. 5	HC	OCK.		1						
			Dua to (or es e consaquanca ot):													
	nsit	nin	ASPIRATION PNEUMONIA													
	The lew requires that the death certificate be executed the hes been signed by the ettending physicien and page 2 should be deteched for use as the burlet-transit	Examiner	Sequentielly list conditions, if eny, leading to immediate	s e consaquance ot):												
260		Medical	if eny, leading to immediate causa. Enter Underlying Cause (Diseese or injury that initiated avants													
68760,			resulting in deeth) Last	uenca of):	of):											
×																
Ď		icia	Port II Other elections and distance	and all the state of the state		I- O					001 014		and a self-action			
P.O. Bo		by Physician/	Pert II. Other algnificant conditions contributing to death but not result									23b. Did tobacco use contribute to the cause of deeth?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown				
T.	es thet igned t be det	γP	CHRONIC OBS	TRUCTIVE	PU	-me	MA	124	1)	SEA.	Se '	105 2LING	) 3 Pro	ышыу не	Unknown	
Records,	aures n sign											an eutopsy	24b. W	era eutopsy	indings	
S	w require been sign	Be Completed									perfo	rmad?	CO	aileble prior t mpletion of o death?		
	The lev ate hes pege 2										40	100 00				
Vital	Physician: The rthis certificate rail director, peg		25. Was casa raterred to medical							Yes 2 Ino 1 Yes 2 Into						
		0	Hospitei:   Hospitei:   Other:   Other:   Other:									What /Canail				
0	Phy or this eral o	F ::	27. Manner of Deeth	28e. Data of Injury (Month, Day Yeer)  28b. Tima of Injury (Month, Day Yeer)  28c. Injury et Work?  28d. Dascribe how injury occurred Work?										γ)		
Division of	To the Hospital or Attending Ph within 24 hours eliter death. To the Funeral Director. After th completely filled in by the funeral	Certification:	1 PNatural 5 Panding 2 Accident investigatio							? fes 2 □ No						
			3 ☐ Suicide 6 ☐ Could not b	28e. Placa ot Injury - At homa, farm, street, factory, office 28f.							Location (Street end Number or Rurel Routa Number,					
		ert	4 ☐ Homicida determined	building, af	building, afc. (Specify) City or						City or Tov	Town, Stete)				
	spita hours nera y fille		29a. Certifier  1 Cartifying Phyeiclan: To the best of my knowledge, deeth occurred at tha tima, date end piece, end due to the ceuse(s) and menner es steted.													
	P Ho Fu	Medical	(Check only one)  2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred at the time, data and placa, end due to the ceuse(s) end manner stated.										;)			
	Withii To th		29b. Signature end titla of cartitier	V	29c. Licansa number					29d. Date signad (Month, Day, Year)						
			30. Neme end eddrass of person who completed cause of deeth (Item Mc R EADY HOSPI7AL 216				150750					6/24/97				
			30. Neme end eddrass ot person who	completed cause of o	leeth (Item 2	3e) (Type.	Print) A.	R	CHARL	Es	FOLACI	YADE A	ND	. ,		
			MCREADY HOSP	17AL =	216	HALL	HIC	HW	44	CRI	SPIELD	ML I	0 218	-17		
	Sta	te	31. Data tiled (Month, Day, Year) JUN2 5 1	997 32. Pegistr	er's Signetu	10 P	11	-		_,_,	, , , , ,	4 4 - 1				
	Registr	ar	JUN2 5	156 JEE	estaments.	a-inande	146									

GLENDON STURGILL

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State of Maryland / Department of Health and Mental Hygiene

AS	_
	Items:
-11	Phy
	/M
	Exa

23a part I,27,28a-f per MEO G-749 7/14/97 dh 1. Decedent's Name (First, Middle, Last)

10b. County

Certificate of Death

2. Date of Death

CECIL

3. Time of Deeth

sician edical miner

Glendon Blaine Sturgill, Sr. 4e. Fecility Neme (If not institution, give street end number)

JUNE 4b. City, Town, or Location of Deeth Port Deposit

29 1997 2:17 A 4c. County of Deeth

**Funeral** 

Director deeth with the Marylend

filed within 72 hours after

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, Important: If Item 27 is merked other any Injury or other traumeth.

**Physician** /Medical

Examiner

ettending physicien end for use es the bunel-transit certificate be executed

ed by the e

signed by t d be detech

sate hes been sig page 2 should b

certificate

this funeral

After

by the

death.

Examiner

Physician/Medical

þ

Completed

Be

2

Certification:

Medical

Baltimore, Maryland 21215-0020

ms 23a or 28a-f show Directo 7 is marked other than "natural", or items traumatic event, the Medical Examiner m þ tal Hygiene.

WHARF SOUTH MAIN ST. 5. Social Security Number 7. Age (In yrs. last birthday) 1 XX 2 □ F

43

If Under 1 Year Days Months Yrs

If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Oct. 22,1953

Month

 Birthplace (State or Foreign Country) Maryland

Maryland

10e State

LOGANS

219-60-9337

Usual Residence of Decedent

Ceci1

10c. City, Town or Location

Port Deposit

10d. Inside City Limits 1 ☐ Yes 2 No

10e. Street end Number

144 Principio Road

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates:

Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.)

21904

U.S.A. Race - American Indian, Bleck, White, etc.

10g. Citizen of Whet Country?

Specify:

1 ☐ Never Married 2 ☐ Married 3 Widowed 4 Divorced

Decedent's Education

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)

10f. Zip Code

1 ☐ Yes 2 ☑ No

White 16b. Kind of Business/Industry

Elementary/Secondery (0-12) Ten Years

College (1-4or 5+)

Construction Worker

Howery Contracting, Inc. North East, Maryland

17. Fether's Name (First, Middle, Last)

Cleveland Blaine Sturgill, Sr.

Mary Gillespie

18. Mother's Name (First, Middle, Malden Surneme)

19a. tnforment's Name/Relationship (Type, Print) Cleveland B. Sturgill, Jr. 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1423 Principio Furnace Road, Perryville, MD 21903

20e. Method of Disposition

20b. Place of Disposition (Neme of cemetery, cremetory or other place)

20c. Location - City or Town, State

1XXBuriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

(Specify only highest grade completed)

Principio Cemetery

7/3/97 Perryville, Maryland

21. Signature of Funeral Service Licensin

MEMOX OF 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line.

22. Name and Address of Fecility Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903-0188

immediate Cause (Fine) diseese or condition resulting in death)

COCAINE AND NARCOTIC INTOXICATION

Due to (or es a consequence of):

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest

Due to (or es e consequence of)

Due to (or as e consequence of)

Pert II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part i.

23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably

24a. Wes en eutopsy performed?

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth?

Approximete Intervel Between Onset end Death

26. Plece of Death (Check only one)

1X Yes 2□ No 27. Manner of Deeth 1 □Naturai 2 Accident

3 Suicide

4 ☐ Homicide

25. Was case referred to medicet

5 Pending investigation 6)(X) Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of injury (Month, Dey Yeer) 6/29/97

Logan's Wharf

28b. Time of injury unknown

28e. Place of tnjury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2√1 No

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

unknown

28f. Location (Street end Number or Rurel Route Number, City or Town, Stefe) S. Main Street, Cecil County

29a. Certifier (Check only one) 1 Certifying Phyeician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) end menner stated. 29c. License number 29d. Date signed (Month. Dev. Yeer)

29b. Signature end title of certifier

31. Date filed (Month, Day, Year)
JUL 01 1997

O.C.M.E

JUNE 29,1997

30. Name end eddress of person who completed cause of days (item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

VEODORE MIANG 32. Registrer's Signature Colin Dividson-Randalle

**DHMH 16 Rev 6/95** 

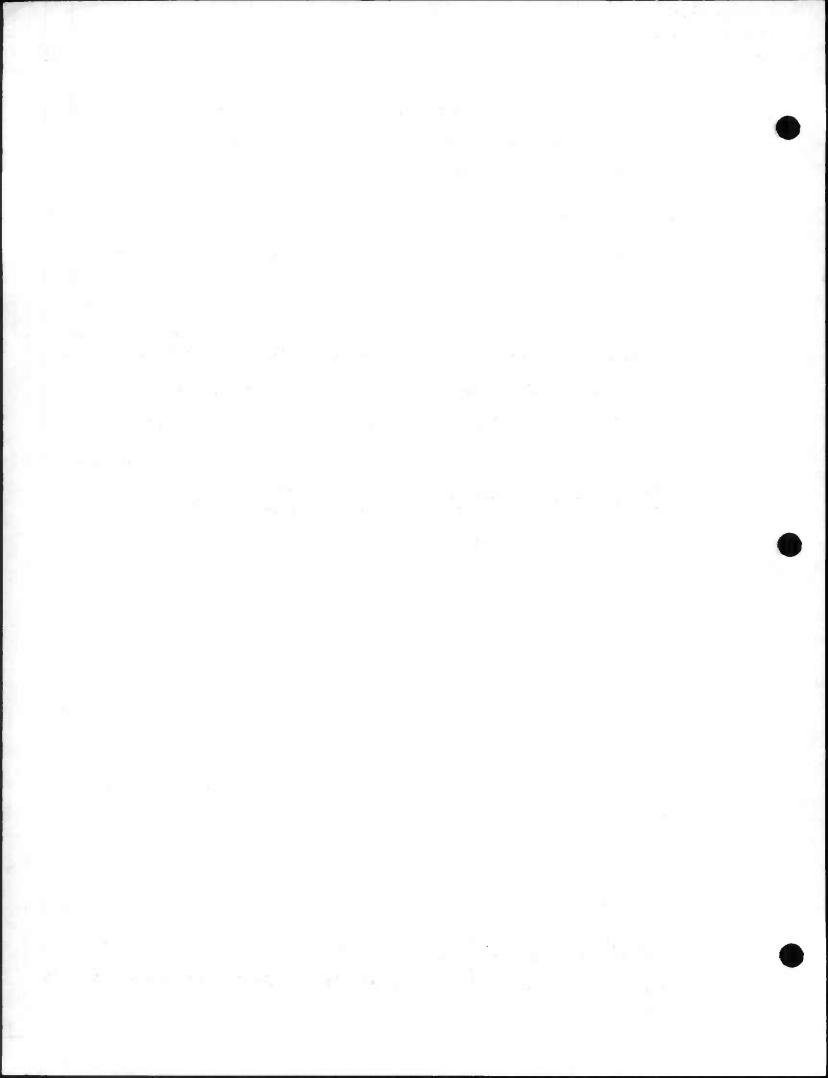
Division of Vital Attending

Box 68760

P.O. 1

Records,

To the Mospital or Attend within 24 hours efter death To the Funeral Director:



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 7 2 1 1 1 1

	an	1. Decedent's Name (First, Middle,						2. Date of De Month	Day	_Yeer	3. Time of Death
/Medic		JAMES EDWIN			JR.				25, 199	7	11:40PM
Examir	er	4e. Fecility Name (If not institution,					4b. City, Town, or I		27. 1 1 1 2 2		
		VA Maryland Hea		4		dar 1 Yaar	Perry I		Cec		
Funeral Director		5. Social Security Number  221–20–9723  Usuel Residence of Decedent	4 M 14 0 -	Aga (In yrs. Ias 52	Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da JULY 7,		9. Birthple Count DELA	ace (State or Forei ry) WARE
Hyjene. ther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at		10a. State 10b. County		10c. City,	Town or Location					10	d. Inside City Limit
1 2	tor	DE NEW CA	ASTLE	WII	MINGTON						1X Yes 2□N
r 28	irec	10e. Street end Number			10f.	Zip Code			10g. Citizen of	Whet Count	ry?
23a c	ai D	412 SOUTH SYCAM	ORE STREE	T		19805	5		U.S.A.		
and Manta Hygiene. I is marked other than "natural", or liems 23s or 28s-f show traumatic event, the Medical Examinet ment be notified at	by Funeral Director	11. Marital Status  1   Naver Marriad 2   Married  3   Widowed 4   Divorced	12. Was Decede Armed Force 1 12 Yas 2 [ If Yes, Give Year or Dete	10°/53 1	[O 1□ Yes	cedent of P pecify Cub 2 No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		ce - Americe ck, White, e	tc.
eturi ical I	te d	15. Decedent's	Education			suel Occup	petion		16b. Kind of B	usiness/Inde	ustry
r than "n the Med	Be Completed	(Specify only highest of Elementery/Secondery (0-12)	greda com <i>pleted)</i> College (1-4c	or 5+)		work done Tuse retire VATE	petion during most of word) (MARINE)	king	MILITAF	RY	
and one wenter hygiene. 27 is marked other than if traumatic event, tra M.	To Be C	17. Fathar's Nama (First, Middla, La JAMES E. SULL)					18. Mother's Nan TERE	ne <i>(First, Midd</i> la, SA HAGGI		na)	
s me		19e. Informent's Name/Relationship	(Typa, Print)		19b. Mailing Addre	ss (Street	end Number or Ru	rel Route Numb	er, City or Town,	Stete, Zip (	Code)
		JANE F. KEOUGH					ROAD, WIL	MINGTON	DE 198	310	
5 = 5		20a. Method of Disposition  1 ☐ Bunal 2 ☐ Cremetion 3  4 ☐ Donation 5 🖾 Other (Spe	□Removal from Sta	te 20b. Pled com	ce of Disposition (*) netary, cremetory o EDRAL CEM	leme of r othar ple [ETER]		JUNE 28	WILMING		
Department of important: If any injury or once.		21. Signature of Funeral Service Lic	uals	Tr	_		uss of Facility NERAL HOM 6, WILMI		DE 19805	5-0866	
-,		23a. Pert1. Enter the disease, or co shock, or heert failure. List on	mplications that caus	ed the deeth.	-						Approximate Intervel Between
sician ledical aminer		Immedieta Causa (Finel disaase or condition resulting in death)	. Respir							1	Onset end Death
	e.	, ,			s e consequence d						
physician and the buriel-transit	edical Examiner	Sequentially list conditions, if any, leeding to immediate ceusa. Entar Underlying Ceuse (Disease or Injury that initiated events	<sub>b.</sub> Metast		conchogen		rcinoma			1	7 months
E E	<u>a</u>	Ceuse (Disease or Injury	C	D - 1- /-							
sic e p	0	thet initieted events				F) -					
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WRC 97-3580-009 WALTER SCHULTZ

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HOLIZ					Cei	rtificat	e of	Death		Re	eg. No.		
	-	1. Decedent's Name (First, Middle, Las	st)							2. Dete of Deet	_		3. Time of Death
Physic	ian	TAT 2\	LTER SC	HUL	r <i>7</i> .					Month	Dey 1	Yeer	2 45 504
/Med				11013.				4h Cihi To	um orloc	JUNE ation of Death		997	2:45 PM.
Exami	ner	4e. Fecility Neme (If not institution, give	street and number)								4c. County		
		3909 6th. ST.				16.1.1-1-1	1 1/	NORT				ALVI	ERT CO.
Funera Director		5. Social Security Number 6. S 173 01 9823 2 Usual Residence of Decedent	EN OFF	e (In yrs. i 84	last birthday) Yrs.	If Under Months	Deys		Min.	8. Dete of Birth (Month, Dey, Apr. 21	,1913	Cour	elece (Stete or Foreign etry) sylvania
Mo ma		10a. State 10b. County		10c. City	, Town or Lo	cation						1	0d. Inside City Limits
with the Meryler a or 28s-f ahow	Director	Maryland Calvert		I	Worth	Beac	h						1√ Yes 2□ No
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23a		3909 6th Street						2071	14		US	SA	
aryland 21215-0020 should be filed within 72 hours after deeth with the Meryland nd Mental Hygiene. marked other than "neturel", or items 23s or 28s-f ahow unatic event, the Medical Evaluation must be notified a	/ Funerai	11. Maritel Status 1 □ Never Married 2 ☑ Married	12. Was Decedent I Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give	No		Was Deced If Yes, spec 1 ☐ Yes			gin? (Spec i, Puerto F	cify Yes or No- Rican, etc.)		e - Americ k, White,	
72 hours	d by	3 Widowed 4 Divorced	Yeer or Dates:	1943-	46						Эрвспу	whi	te
within 72 hane.	Completed	15. Decedent's Ed (Specify only highest grader) Elementery/Secondery (0-12)	ucetion de completed) College (1-4or 5	i+)	16e. Deced (Give life. I	dent's Usue kind of wo DO NOT us	el Occu ork done se retire	petion during most ed)	t of workin	g	16b. Kind of Bu	usiness/în	dustry
d 212 filled withi Hygiene. wither then	8	7		_	auto	body	pai	nter/1	repai	rman	D.C. F	ire D	ept.
Maryland 21215-0020 Id 2 should be filed within 72 hours aff the and Mental Hygiene. It is marked other than "neturel", or traumatic event, the Medical Expirit	To Be	17. Father's Neme (First, Middle, Last) Walter Schultz								(First, Middle, N nashive		10)	
M dd2		19e. Informent's Name/Relationship (7 Mrs. Mildred Schu		e				above		Route Number,	City or Town,	State, Zip	Code)
Heer Heer		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. P	lece of Dispo	sition (Ner	me of			Dete	20c. Location -	City or To	own, Stete
Baltimore, pemit. Pages 1 en Depertment of Heel Important: if Item 2 any injury or other once.		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		-3.	emetery, crer Vetera	•			7-	-3-97	Chelten	ham.	MD
alti nit. I ortan ortan inju		21. Signature of Funeral Service Licen						ess of Fecilit				-	
Balt permit. Depertrimports any inju		Nilliam R.	g		- 8	325 M	ıt.	Harmon	ny La	usch Fu ne, Owi	ngs, M		P.A. 0736
Physician /Medicai		23a. Pert1. Enter the disease, or comp shock, or heart feilure. List only of								respiretory erre	est,		Approximate Intervel Between Onset end Death
Examiner		Immediate Ceuse (Final disease or condition resulting In deeth)	e. METAS	5TAT	IC PR	OSTR	KAT I	E CAN	CER				
D ==	ner			Due to (o	r es e consec	quence of):							
O, e execute ian and urial-trans	Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury	D	Due to (or	r es e consec	quence of):							
octificate be executed ding physician and itse as the burial-transit	/Medicai	thet initiated events resulting in deeth) Lest		Due to (or	es e conseq	uence of):							
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o dead the all hed for	Sic	Pert II. Other significant conditions co	ntributing to death bu	ut not resu	ılting in the u	nderlying c	euse gi	iven in Pert I.		23b. Did to	bacco use co	ntribute to	the cause of death?
S, P.O. Bies that the death igned by the atterbed for	y Physician	Arterioso	lerotic	Car	diova	scul	.ar	Dise	ase	1 □ Ye	s 2□ No	3 ☐ Proi	babiy 4 Unknown
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The law rate has b	Completed										CTION s 2 No	of	deeth?
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vision of Vita Attanding Physician: r death. setor: After this certifica by the funerel director, i		27. Manner of Deeth 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident investigation	28e. Dete of Injur (Month, Day		28b. Time of Injury		28c. Inju		2	8d. Describe ho		-	77
Division of Vital Records, if or Attanding Physician: The law requires the after death.  Director: After this certificate has been signed in by the fumerel director, page 2 should be to	Certification:	3 Suicide 6 Could not be determined		ury - At ho	me, farm, str	eet, factory	y, office		2	8f. Location (St. City or Town		er or Rure	I Route Number,
Divisio To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the ti	edicai C	29a. Certifier (Check only one)  1□ Certifying Phy 2X Medical Exam	rsicien: To the best of iner: On the basis of and manner sta	examinat	wledge, death ion end/or Inv	n occurred vestigation	at the ti	ime, dete en opinion, dee	d plece, eath occurre	nd due to the ce d et the time, de	euse(s) end me ete end place,	enner es s and due to	teted. the cause(s)
To th To th comp	Me	29b. Signature and title of certifier	Wrigh-M	D		290	c. Licen	o.C.I	М.Е.		9d. Date signe		Dey, Year) 1997
10+1		30 Name and address of person who o			23e) (Tyme	Print)	_						

Donald G. Wright M.D. 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Yeer) 32. Registrar's Signeture 1997 > Jahi Davilson Radall JUN 3 0

State

Registrar

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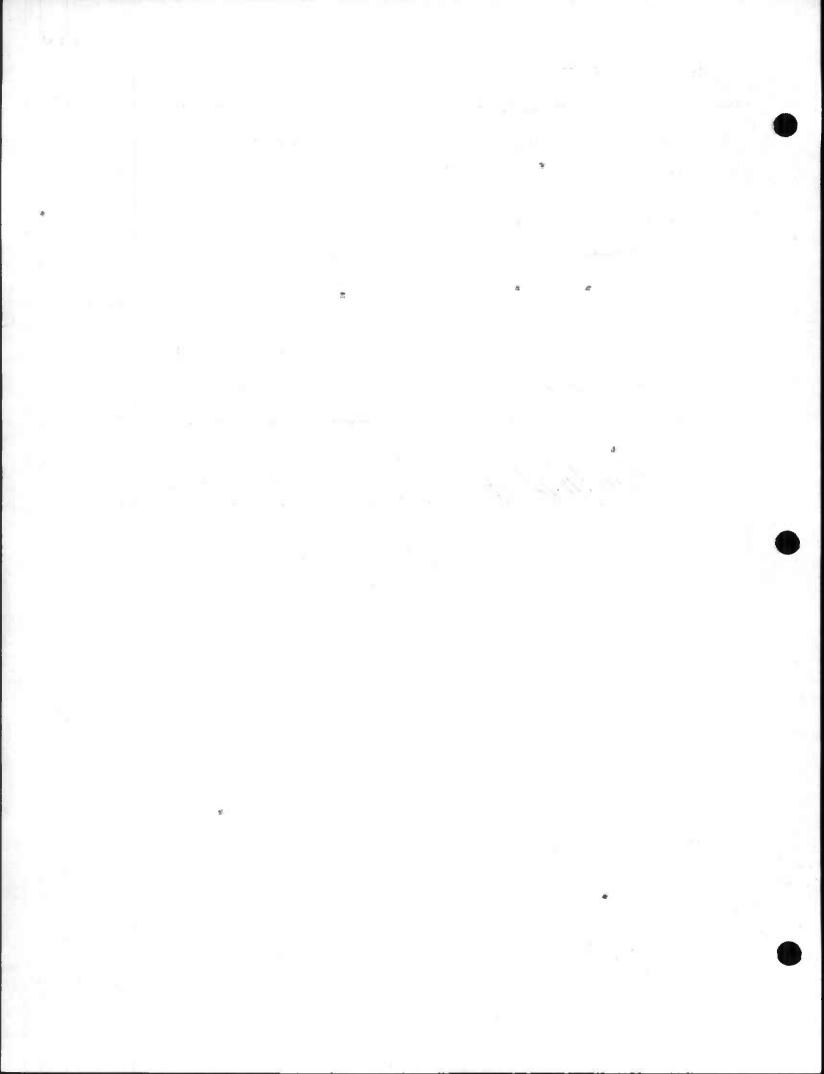
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Daath Ralph Justin Sypher, Jr. Month **Physician** Yaar June 18, 1997 5:30 AM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Daath 4c. County of Death **Examiner** St. Mary's Nursing Center Leonardtown St. Mary's Months Days Hours Min. May 30, 1907 5. Sociel Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1 M 2 □ F 577-14-7701 90 Yrs. Director Pennsylvania Usual Rasidance of Dacedani with the Maryland 10a. Stata 10b. County 10c. City. Town or Location 28a-f show 10d. Insida City Limits the Medical Examiner must be notified at Director 1 ☐ Yas 2 ■ No Maryland St. Mary's California 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? ò 45398 Sypher Road 20619 items 23a United States daath Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status e filed within 72 hours after day Hygiane. 1 ☐ Naver Married 2 ■ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ■ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elementery/Secondary (0-12) College (1-4or 5+) Electronic Engineer Defense/U.S. Navy permit. Pagas 1 and 2 should be filed to Department of Health end Mantel Hygis Important: If Itam 27 is marked other any Injury or other traumatic event, It 17. Fether's Nama (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Surnama) Justin Ralph Sypher, Sr. Rhea Weatherwill Gumbs 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rurel Routa Number, City or Town, Stata, Zip Code) Jane Sypher, Daughter 45211 Cove Manor Road, California, Maryland 20619 20b. Place of Disposition (Nama of cemetary, cramatory or othar place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ■ Cramation 3 ☐ Ramoval from State 6-18-1997 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Michael K. Blankenship, MO852 22. Nama and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Maryland 20650-0279 23a. Part1. Enter the disease, or complications that stused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Onsat and Daath Physician metostote Long Concer /Medical Immadiata Cause (Final disaasa or condition rasulting in death) Examiner Dua to (or es e consaquance of). Examiner shysician and the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Disaese or Injury that initiated avants rasulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequance of) 98 P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobação usa contribute to the cause of death? 1 √ 10s 2 □ No 3 Probably 4 Unknown signed b Records, þ 24b. Wara autopsy findings eveilable prior to complation of causa of daath? Completed 24a. Was an autopsy performed? walkin 25. Was case referred to medical examiner? T ☐ Yes 2 ☐ No cartificata Division of Vital or Attending Physician: Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To this within 24 hours ettar daath.

To the Funerel Director: After this complately filled in by the funaral of 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Cartifian 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the ceuse(s) end manner as stated. 2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. the th 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licansa number 30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print) 24035 THREE NOTCH Rd. Hollywood, 700 20636 Jalin Davidson-Randall FEDERLE MND DAULD M. 31. Data filad (Month, Day, Yaar) State Registrar -18-

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 2 1 1 3 State of Maryland / Department of Health and Mental Hygiene

	Amended	Ιt	em#10e,19b perFH	G778				rtificate of	neaith and i <i>Death</i>		Reg. No.			
		П	Decedent's Name (First,					11		2. Date of Dea		Veer	3. Time	oi Death
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	Examir		4a. Facility Name (If not ins						4b. City, Town, or I					
1			45775 Sherr	an Dr	ive				Lexington	Park	St.	Mary	s	
	Funeral		5. Social Security Number	6. 8	Sex	7. Age (In y	rs. last birthday)	li Under 1 Year	II Under 24 Hrs.	8. Date of Birt	h			or Foraign
	Director		231-26-5862 Usual Residence of Deced		1 ■ M 2 □ F	70	Yrs.	Months Days	Hours Min.	May 5,			m) ginia	
	anyland ehow	7	10a. State 10b. C			10c.	City, Town or Lo	cation				10		City Limits
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	1 P P P P P P P P P P P P P P P P P P P	100	10e. Street and Number Sheeran 45775 Sherra					10f. Zip Code		1	10g. Citizen of 1		*	
	ath v	<u>a</u>	45775 Sherra	n Dri	ve			20653			United	State	es	
21215-0020	n 72 hours after death with the Maryland "natural", or Items 23s or 28s-f show solical Experient must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 □ Div		12. Was Deci Armed Fo 1 Yes II Yes, Gir Year or D	rces?		Was Decedent of f f Yes, specify Cub 1 ☐ Yes 2 ■ No	Hispanic Origin? (Span, Mexicen, Puerti Specify:	pecify Yes or No- o Rican, etc.)		e - America ck, White, e	etc.	
5-0	72 h	etec	15. De	cedent's Ed			16a, Dece	dent's Usual Occup	pation	kina	16b. Kind of B	usiness/Ind	ustry	
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nd	a Hy	Be	17. Father's Name (First, N	liddle, Last,	)				18. Mother's Nan	ne (First, Middla,	Maidan Suman	ne)		
<u>yla</u>	should be filed within na Mental Hygiena. marked other than imatic event, tha M	T <sub>0</sub>	Alexander Al	ley S	mith, S	r.			Helen A	Aubrey V	aughan			
Maryland	s 1 end 2 should be filed withi f Health and Mental Hygiena. Itam 27 is marked other than other traumatic event, the M		19a. Informant's Name/Rei		Type, Print)				t a <i>nd N</i> um <i>ber</i> or Ru					
≥ .	end saith		Ethel J. Smi	th	Wif	е	45775	Sharran	Drive, I	Lexingto	n Park,	MD 2	0653	
ore	of He		20a. Method of Disposition			20b	. Place of Dispo	sition (Name of natory or other pla	ice)	Date	20c. Location -	City or Tov	n, State	
Ĕ	Pag nat: H		1 ☐ Burial 2 ■ Crem 4 ☐ Donation 5 ☐ Ot		JHemoval Irom	State		tan Crem		5/17/97	Alexan	dria.	Vir	oinia
Baltimore,	permit. Pages 1 end Department of Healt Importent: If Item 2: any Injury or other: QDCS.		21. Signate of Ineral 6	of the	Man!	14			ess of Facility			ur ru ,	, 11 8	SIIIIa
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	/Medical		Immediate Cause (Final disease or condition		F	cook		Carcu	) () (a. (a.			1	100	24.6
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	outed od rensi	Examiner	Sequentially list conditions		b. 130	Due to	(or as a consec	uence oi	Your					
ó	axes en er rial-t		Sequentially list conditions if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury	ė			100000000000000000000000000000000000000					1		
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	tifica ng ph es th		resulting in death) Last	- L			,	,				i		
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Records,	been should	Completed								24a. Was a		ava	re eutopsy ilable prior npletion of leath?	r to
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of Vital	ician: The certificata ractor, pag	Be	25. Was case referred to m	edical					26. Place of Dea	th (Check only o	na)			
>	ysloi Is cer dirac	TOE	examiner? 1 ☐ Yes 2 No		Hospital:	npatient 2	☐ ER/Outpatier	t 3 DOA Ot	har	ome 5 Resid		er (Specify	)	
0	Attending Physician: or death. sctor: After this certific by the funeral director,		27. Manner of Death		28a. Date		28b. Time of	28c. Inju Wo		28d. Describe h				
Ö	ath. r: After e funer	atio		Pending nvestigation		in, Day raar)	Injury		Yes 2 No					
Division	or Attandil after death. Director: A d in by the fu	lfic		ould not be letermined	286. Place	ol Injury - Al	t home, farm, str	eet, lactory, office	A .	281. Location (S City or Tow	Street and Numb	er or Rural	Routa Nu	m <i>ber</i> ,
Ö	s afte	Certification:	4 🗆 Homicide		Dulidi	ng, etc. (Spa	icity)			City or Tow	m, Siaia)			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical (	29a. Certifier 1 Ce (Check only one) 2 Me	rtifying Ph dical Exam	niner; On the ba	best of my k asis of exami ner stated.	nowledge, deeth	occurred at the ti	me, date and place opinion, death occu	, and due to the o	cause(s) and modate and place,	anner as sta and due to	ited. the cause	(s)
	o the	Me	29b. Signature and title of o	ertifier	4 /			29c. Licens	se number		29d. Date signe	d (Month, E	Day, Yaar)	
	- s - ö		1/11/11	1///				N2	9979		1	10-		
			20 Name and a common	im	4	a of starts of	lam 00-1 /7	U S	1171		6/17	11		
			30. Name and eddress of p	1/	completed caus	M/) -	tem 23e) (Type,	Talle L	9979 top. (	ounard	form V	2010	065	-0
	Sta	te	31. Date filed (Month, Day,			egistrar's Sig	nature	, , , , ,	7.	0 - 10 ( 0 - ( )		, , _	~	
	Registr	-	JUN 1	7 199	1 July	Davides	mature Mandall							



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						(	Certifica	te of	Death	F	leg. No.		
	Physic		1. Dacedant's Name (First, Mic	thel F.	S	eitz				2. Date of Daa Month	th Day	Yaer	3. Tima of Deat 1:00PM
	/Medi Examii		4a. Facility Neme (If not institut		number)					June Location of Daath	4c. County		1.00111
	Funeral Director		5. Social Sacurity Numbar  219–36–1824 Usual Rasidence of Decedant	6. Sax 1  M 2  F	7. Age (In yrs	a. last birth	Month	er 1 Yea Days		s. 8. Data of Birth	Year)	Coun	lace (Stata or Ford try) ginia
	a-f show	ctor	10a. State 10b. Cour	roll	10c. C	ity, Town	or Location Syk	esvi	lle			10	0d. Insida City Lim 1 ☐ Yas 2 💢
	ath with the 23a or 28	ral Director	10e. Street and Number 615 Streaker	Road			10f. 2	ip Coda 21	784		0g. Citizan of V		try?
020	urs efter des el', or items	by Funeral	11. Marital Status 1 ☐ Navar Married 2 ☐ M 3 ☐ Widowad 4 ☐ Divorc	arried Armed  1 Ye If Yas.	acedant Evar in Forcas? s 201 No Giva r Datas:	U,S.	If Yas, sp	ecify Cul	Hispanlc Origin? (: ban, Maxicen, Pua ) <i>Spacify:</i>	Specify Yas or No- rto Rican, etc.)		e - America ck, Whita, c	
21215-0020	s 1 end 2 should be filed within 72 hours efter death with the Marylend if Health end Mental Hygiene. Item 27 Is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Evanther must be notified at	Completed	15. Deced (Spacify only high Elementary/Secondary (0-12	ant's Educetion hast grada complate ) College	d) a (1-4or 5+)	- 9	lifa. DO NOT	rork done use retir	i during most of wo ed)	orking	16b. Kind of Bu	usiness/Ind	lustry
	d be filed ental Hygic ced other c event, III	Be	17. Fathar's Nama (First, Middle Irvin Le				Nurses	Ald	18. Mothar's Na	ama (First, Middla,			:e
Maryland	id 2 should be ith end Mental I	ပို	19a. Informant's Name/Relation Mr. Stewart P	nship (Typa, Print)					at and Number or F	Va Ann Po Rural Routa Numba	r, City or Town,		Coda)
Baltimore,			20a. Mathod of Disposition  1 XBurial 2 Cramation 4 Donation 5 Other	n 3 Removal fro	20b.	Placa of E camatary,	Disposition (No cramatory of iew Me	ama of other pla	ace)	kesville, Data 6/28/97	MD 217 20c. Location - Sykesv	City or To	
pair	permit. Page Depertment of Important: If any injury or once.		21. Signature of Funaral Sarvio	ca Licensaa K. Hau	40		22. Name HAI Syk	nd Addr GHT esvi	ess of Facility FUNERAL 1 11e, MD 2	HOME & CH 21784 (41	APEL (E	30x 19	95)
	Physician /Medical Examiner	ier	23a. Part1. Enter the disaase, shock, or heart failura. Li Immediata Cause (Final disaasa or condition resulting in daath)		ncreat	ic	100	oca	reihorn		-		Intarval Batween Onsat and Death
מסיסט אחם	The law requires that the death certificete be executed ate hes been signed by the ettending physician and page 2 should be deteched for use as the buriet-trensit	an/Medical Examiner	Sequentially list conditions, if any, leading to immadiate couse. Enter Undarlying Causa (Disaase or Injury that initiated events rasulting in daath) Last	c			nsequance of						
	es that the deat igned by the ett be deteched fo	Physician/	Part II. Other eignificant condi	tions contributing to	death but not ra	sulting in t	ha undarlying	causa g	ivan in Part I.	23b. Did to			the cause of des
or vital necords,	aw requires as been sign 2 should be	Completed by						_		24a. Wes e parfor	en eutopsy mad?	ava	ara autopsy finding ilabla prior to nplation of causa deeth?
la La		Be Corr	25. Was casa rafarred to madic	al					26. Place of De	1 □ Y		1	Yes 2 No
	ing Phys	ို	examiner?  1  Yas 2 No  27. Manner of Death  1 Natural 5 Pendent invasions	28a. Da	Inpatient 2 [ te of Injury onth, Day Year)	28b. Tin	na of	28c. Inju	thar: 4 Nursing lary at ork?	Homa 5 Resid	ence 6 Oth		)
DIVISION	P # C	Certification:	4   Hornicida	mined 28a. Pla bui	ce of Injury - At I Iding, atc. (Spec	ify)				28f. Location (S City or Town	n, Stata)		
	To the Hospital within 24 hours of To the Funeral completely filled	edical	29a. Certifier 1 ☑ Cartify (Check only one)	ring Phyaician: To t al Examinar: On tha and ma	he best of my kn basis of axamin annar statad.	owledga, o ation and/	death occurre or Investigation	d at the t n, in my	ime, date and plac opinion, daath occ	e, and dua to tha c urred at tha tima, d	ausa(s) and ma ata and place,	innar as st and dua to	ated. tha causa(s)
	To the To the Comple	M	29b. Signeture and title of certif	W)	M.D	,	2		3 3 6 8 1	2	9d. Date signed $6/2$	6 /87	Jay, Yaar) <b>7</b>
			30. Nama and addrass of person	n who complated ca	use of death (Ita	m 23a) (T	ype, Print)	21	184				
	Sta		31. Data filad (Month, Day, Yea	6 1997 32	Pregistrar's Sign	atura	11						

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			Cei	rtificate of	f Death		Reg. No.		
П			Decedent's Neme (First, Middle, Last)			2. Deta of De			3. Time of Death
	Physic		Savilla E. Shaffer			June 2	24, 199	Yeer	1990
ч	/Medi		4a. Fecility Neme (If not institution, give street end number)		4b. City, Town, or L	*			1100
2	Exami	ner					1		
L		Į.	1414 N. Main St.		Hampste		Carı	roll	
	Funeral		5. Social Security Number 6. Sex 7. Aga (In yrs. lest birthday)	If Under 1 Year Months Days		8. Date of Birt (Month, De	th v. Year)	9. Birth	place (State or Foraign
1	Director		215-58-3663 1 1 M 2/1 74 Yrs.			9/21/	/22		ryland
	D .	1	Usual Residence of Decedent						
	how		10a. State 10b. County 10c. City, Town or Lo	ecation				1	I Od. Inside City Limits
	M T	Ö	MD Carroll Hampstea	h.e					1 Yes 2 No
	28 28	9	10e. Street end Number	10f. Zip Code			10g. Citizen of	Whet Cour	ntry?
	with o		1414 N. Main St.	21074					yı
	72 hours after death with the Maryland natural, or Hems 23a or 28a-f show	Funeral Director					U.S.		
	er de	5	Armed Forces?	Yas Dacedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexicen, Puerto	ecity Yes or No Rican, atc.)		ck, White,	can Indien, etc.
20	aff o		1 Naver Married 2 Merried 1 Yes 2 No	1 □ Yes 2 ¥No	o Specify:		Specif		
21215-0020	in in in	d by	3 Widowed 4 □ Divorced Yaar or Dates:				Openi	Wh:	ite
5	72 h	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	dent's Usuel Occu	upation	ina	16b. Kind of B	usiness/In	dustry
21	within iena. than	dr	Elementery/Secondary (0-12) College (1-4or 5+)	DO NOT use retir	e during most of work red)	"ig			
21	d wi	10		d prepa	ration		Schoo	ol ca	afeteria
D	off of H	Be	17. Fether's Neme (First, Middle, Last)		18. Mothar's Name	a (First, Middla,	Maiden Sumen	ne)	
Maryland	2 should be filed with and Mantal Hygiena. is marked other than aumatic event, the M	ToB	Charles Newley						
5	M M	-	Charles Naylor  19a. Informent's Neme/Relationship (Type, Print)  19b. Meilir	a Address /Stra	Daisy et end Number or Run	Burri	S-City or Town	Canan Zin	Code
Ma	h ar r is								
	s 1 and 2 should be filed within 72 hours after death with the Marylar f Haatth and Mantal Hygiena. It has the marked other than "natural", or liems 23a or 28a-f show then traumatic event, the Madical Examiner must be notified at		Dianna Shaffer- Daughter 84 F	East Pa	donia Rd	. Time	nium,	MD 2	21093
0			20a. Method of Disposition 20b. Place of Disposematary, cremited and the state 2 □ Cramation 3 □ Removal from State		lece)	Date 6 / 2 0 / 0	20c. Location -	City or To	own, Stete
Ē	Pag Int: I		4 □ Donetion 5 □ Other (Specify) Falls F	Rd, Uni	ted Meth	0/20/8	BUT	Ter	, MO.
altimore,	permit. Pages 1 a Department of Has Important: If Itam: any Injury or othe once.		21. Signature of Funeral Service Licensee 22	. Name and Add	ress of Facility				
8	Departing any It		1 X To (1) IT)	Eline	Funeral	Home 9	34 S.	Mair	n St
		-	23a Part I Exter the dispass or complications that assemble death. Do not ask						MD 21074
			23a. Part1. Enter the disease, or complications that ceused the daath. Do not enter shock, or heart failure. List only one ceuse on each line.	er tha mode of dy	/ing, such es cerdiac	or respiretory er	rrest, 4		Intarval Between
	Physician		and the second s		b 21.			i	Onset end Deeth
	/Medical Examiner	ш	Immediate Cause (Final disease or condition resulting in deeth)  a. VENTRICUL  Due to (or es e consect	AR F	JRKILL	ATTO	N	i	9 metam
	LAUITING		resulting in deeth)  a.  Due to (or es e consequence)	uence of):		_	-		
	75 AT	Examine	Attoriselord	UT H	le out Di	Sean	50		Cyean
	certificata be executed iding physician and ise as the burial-transit	an l		,		9	•		9
o,	an an		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury						
68760,	ysicii e bu	/Medical	thet initiated events	nance off.					
9	ifical phy as th	P	resulting In deeth) Lest	derice or).					
X		2	d						
m	o tta	Physician							
o.	the d	ysi	Part II. Other eignificent conditions contributing to death but not resulting in the un	nderlying ceuse g	iven in Pert I.	23b. Did t	obacco use co	ntribute to	the cause of death?
۵.	law requires that tha da as been signed by the a s 2 should be detached f					1 7	Yes 20 No	3 ☐ Prol	bably 4 Unknown
Ś	es ti gne be c	by							
ord	v require been sig should b	Pe					en eutopsy rmad?	24b. W	ere eutopsy findings ailable prior to
S	s be	pie				porto	illiau:	CO	mpletion of cause deeth?
æ	0 - 0	Completed					/		
a	icate icate ir, ps					101	as 211100	11	Yes 2□ No
Vital Records,	Physiclan: The this certificata ral director, par	Be	25. Was case referred to medical exeminer?		26. Plece of Deat	h (Check only o	ne)		
ō	2 00 0	ို	1 Inpatient 2 ER/Outpetian	I SLI DUA	ther: 4 Nursing Ho	me 5 A Rasio	dence 6 Oth	er (Specif	y)
Ē		on:	27. Menner of Death 1 □ Maturel 5 □ Pending 28e. Dete of Injury 28b. Time of Injury Injury	28c. Inju	ury et ork?	28d. Describe h	now injury occur	red	
Division	Attanding ir death. actor: Aftai by the funa	ati	2 Accident investigation	M 1	Yes 2□No				
Ξ	of Attand after death Director: A d in by the f	ti ji	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, streen building, etc. (Specify)	eet, factory, office	)	28f. Location (5 City or Tox	Street end Numb	er or Rura	I Route Number,
	al or A s after al Dirac ad in by	Certification:	building, die. (opdeny)			ony or ron	n, olulo,		
	To the Hospital or At within 24 hours after or To the Funeral Diract complataly fillad in by		29a. Certifier 1 Certifying Phyelclen: To the best of my knowledge, deeth	occurred et the t	time, dete end plece,	end due to the	ceuse(s) end me	enner es si	teted.
	P Hc	edicai	(Check only one) 2 ☐ Medical Examiner: On the basis of examinetion end/or invend menner stated.	estigation, In my	opinion, deeth occurr	ed et the time,	date end place,	end due to	the cause(s)
	Within To the Company of the Company	M	29b. Signature end title of certifier	29c. Licen	nse number		29d. Date signe	d (Month,	Dey, Year)
	- 2 - 0		Tolmacled Napame	DI	8-21101		6/9	86	47
		-		VI	3000		70	70	1-0
			30. Name end eddress of person who completed cause of death (Item 23e) (Type, I	Print A P	core ma	WES	IMINS	15/	- ' []
			CHIP POLET ( PONCH)	11			211	1/	
	Sta		31. Date filed (Month, Dey, Year)  JUN 2 6 1997  32. Registrer, Signature	.11				-	
	Registr	ar	JUN 2 6 1997 Mindleson Rand	LAG					

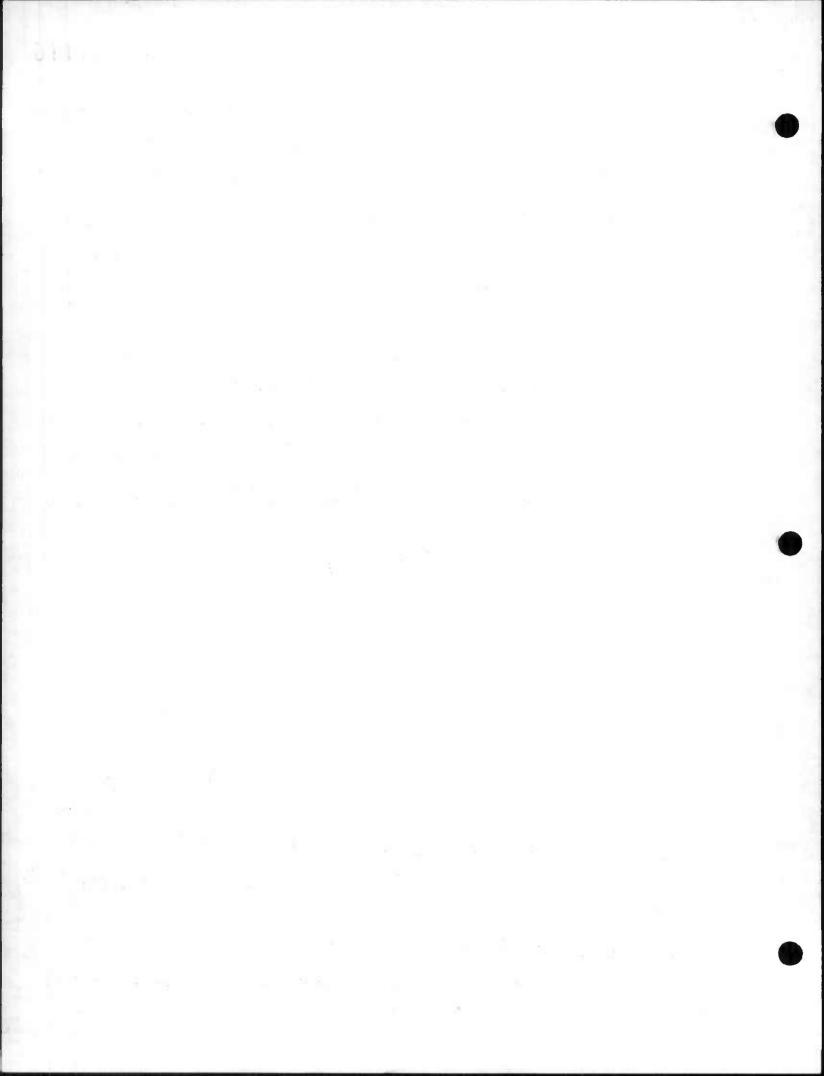
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LVIN		1 Decedent's N	łame (First, Middle, Le		-	Certificate of			Reg. No.	. 41110
/Me	sician edica minei	Melv 4e. Fecility Nam	in F. Swine (If not institution, given	anke re street end numb				2. Dete of De Month  JUNE , or Location of Deeti	Day 15, 19	of Deeth
Fune Direct		5. Sociel Securi	ty Number 6. 9		Age (In yrs. lest bin	Months Deve		Hrs. 8. Date of Bir Min. (Month, De	th by, Year) 14 194	9. Birthplece (State or Foreign Country)  1. Maryland
Marylend a-f show	100	10a. Stete	10b. County (trans	ient)	10c. City, Town	or Location nsient)				10d. Inside City Limits
ath with the s 23a or 28	rotoerio iere		sient)				nsient			d States
72 hours efter death with the Maryland "natural", or Items 23a or 28a-f show addal Exemple must be notified at	hv Funeral	3 ☐ Widowe	us Merried 2⊡ Married ed 4∭ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? No	13. Was Decedent of If Yes, specify Cu  1 ☐ Yes 2X No		? (Sp <i>eci</i> fy Yes or No uerto Rican, etc.)	Specify	e - American Indian, kk, White, etc.  White
J within 72 ho jiene. r than "natur	Completed	(S Elementary/S	15. Decedent's Expecify only highest greecondary (0-12)	ducetion de completed) College (1-4	Dr 5+)	Decedent's Usuel Occu (Give kind of work done life. DO NOT use retir	ipetion a during most of ed)	working		usiness/Industry
be filed tal Hygi d other	a a	17. Father's Nar	ne (First, Middle, Last,		S	salesman		Name (First, Middle,	Maiden Sumem	tail <sub>e)</sub>
ges 1 en of Heal		19a. Informant's Richa 20e. Method of	s Name/Reletionship ( rd B. Swa Disposition 2 Cremation 3 Con 5 Other (Specification 1)	Removel from Sta	rother 20b. Place of cemeter	Mailing Address (Street  1382 Ali  Disposition (Name of y, crematory or other plant  Disposition Park Co	son Co ကြော်/26/	urt, Wes	tminst 20c. Location -	Stete, Zip Code) er, MD 21158 City or Town, Stete ore, MD
		21. Signature of	Funeral Service Licer	Pristo - x	Sweitzer	22. Name end Addi	ress of Fecility S Fune ashing	ral Home	& Cha	
Physicia /Medic Examin	al er	Immediate Cau disease or cond resulting in deal	dition	a	Due to (or es e o	and No	j			3.53.51.53.53.53.53.53.53.53.53.53.53.53.53.53.
Jeath certificete be executed attending physician end of or use es the buriel-transit	W	Cause (Disease thet initieted eve resulting in deal	ents	b	Due to (or es e c					
that the cled by the deteched	by Physician/M		gnificant conditione c	ontributing to deat	n but not resulting In	the underlying cause g	iven in Pert I.	23b. Did	V	ntribute to the cause of death
aw requi	pieted								en eutopsy rmed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
E 88	o Be	25. Wes cese re examiner?	eferred to medical	Hospital:	atient 2 ☐ ER/Out	petient 3 DOA	ther:	Deeth (Check only o		Yes 2 No
or Attending efter death. Director: After	Certification: T		eeth 5 Pending investigation 6 Could not b	28a. Dete of I	njury Day Year) 28b. T	ime of light with the street of the street o	ury et ork? ] Yes 2 No	Shed	how injury occurr	er (Specity) SCENE  ed  Self  er or Rurel Route Number,  L-RIVO Ron3
To the Hospital within 24 hours To the Funeral completely filled	Medical C	29a. Certifier (Check gar)	2 X Madical Exam	yelclen: To the be niner: On the basis end menner	of exeminetion end	death occurred at the t	opinion, death o	occurred et the time,	date end place, e	end due to the ceuse(s)
Viil To	-	Y	ddress of person who	rlema	2	00	CME			16 (Month, Dey, Yeer) 15, 1997

State Registrar 31. Date filed (Month, Day, Year) 1997 June distants Stoneture



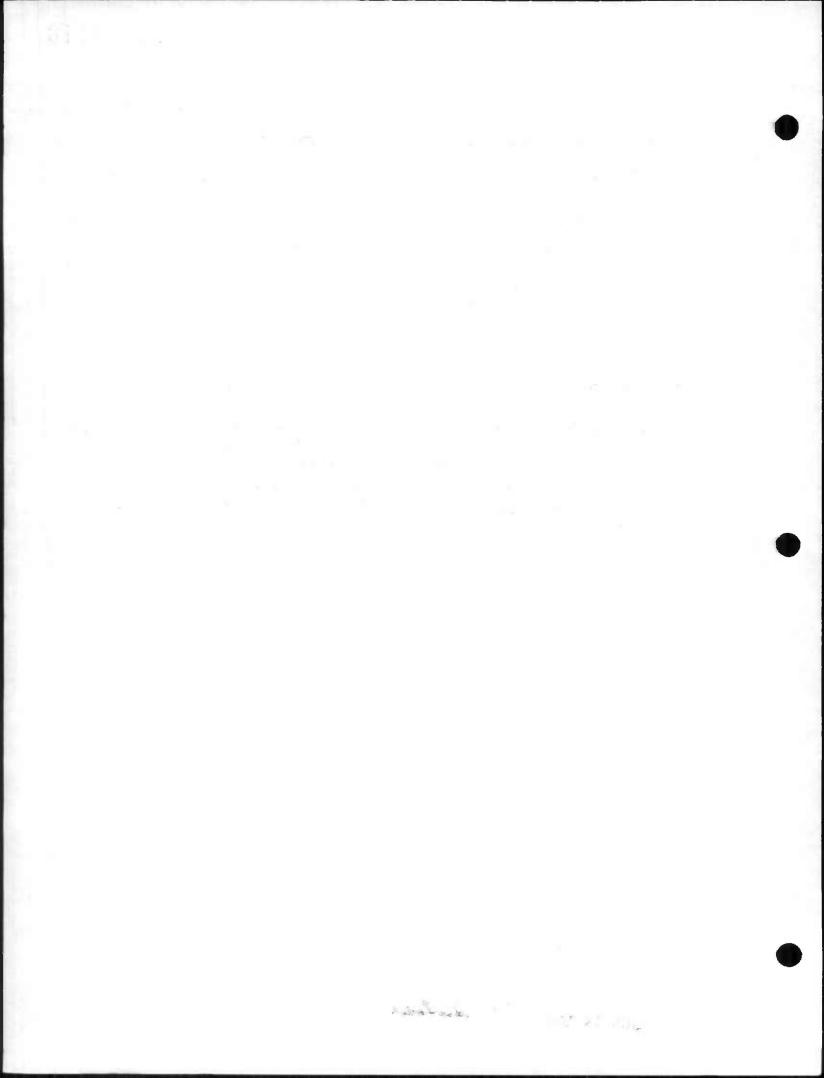
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State of Maryland / Department of Health and Mental Hygiene 9 7 2 1 1 7

						Certificate o	f Death	F	Reg. No.		
	Dharata		1. Decedant's Nama (First, Middla, Las	it)				2. Data of Das Month	th Day	Yaar	3. Tima of Death
	Physic /Medi		WILLIAM ANTH	ONY STE	GER, S	R.		7	1 1	97	1445
	Exami		4a. Facility Nama (If not institution, give				4b. City, Town, or	Location of Death	4c. County	of Death	
			Atlantic General	Hospital			Berlin		Wor	ceste	er
	Funeral		Social Security Number     6. Security Number		(In yrs. last bir	thday) If Under 1 Year Months Day					iace (Stata or Foraign try)
L	Director		219-01-4924 Usual Rasidence of Decedant	<b>⊠</b> M 2□F	76	Yrs.	TIOUIS WIIII	4/23/	21	Cour	MD .
	how		10a. Stata 10b. County		10c. City, Town					1	Od. Insida City Limits
	Ma Me	to	MD Worces	ter	Ocea	an City					1X Yas 2 No
	h the	Director	10e. Street and Number			10f. Zip Code	1		10g. Citizan of V	Vhat Cour	itry?
	h wit		211 St. Louis	Ave.		218	842		USA		
	deed	Funeral	11. Maritai Status	12. Was Dacedant Ev	ar in U,S.	13. Was Decedant o	f Hispanic Origin? (S	pacify Yas or No-		e - Amaric	
Maryland 21215-0020	in 72 hours after deeth with the Maryland "naturel", or items 23s or 28s-f show ledical Exeminer, must be notified at	þ	1 ☐ Nevar Marriad 25€ Marriad 3 ☐ Widowad 4 ☐ Divorced	Armed Forcas?  1 ☑ Yas 2 ☐ No If Yas, Giva Yaar or Datas:	wwii	1 □ Yas 2 N		to Hican, atc.)	Specify	k, Whita, w	nite
5-0	72 h	Completed	15. Decedant's Ed (Specify only highast grad		16a.	Decedant's Usual Occ	supation	rkina	16b. Kind of Bu	usinass/înc	dustry
2	within ene.	np du	Elementery/Secondery (0-12)	College (1-4or 5+	)	(Giva kind of work dor lifa. DO NOT usa reti	ired)	'All'y			
2	TI CO In The Control of the Control	ပ္ပ	12			Storekeepe			Marine		ply
2	0 = 0 =	Be	17. Fathar's Nama (First, Middla, Last)				18. Mothar's Na	ma (First, Middla,	Maiden Sumam	a)	
Sa		10	William Anthony	Steger			Vero	nica Bud	a		
a	ts show		19a, Informant's Name/Raiationship (T	ype, Print)	19b.	. Mailing Addrass (Stre	et and Number or R	urel Routa Numbe	r, City or Town,	Steta, Zip	Coda)
	5 7 8 5		Violet Steger/ V	Vife		211 St. Lo	ouis Ave.	Ocean (	City, M	D 2	1842
ore	of Heel of Heel I Nem 2 r other		20a. Mathod of Disposition		20b. Place of cematar	Disposition (Nama of	olace)	Data	20c. Location -	City or To	wn, Stata
Ĕ	Peges nent of 1 mt: If its iry or o		1 ☐ Maurial 2 ☐ Cramation 3 ☐ I 4 ☐ Donation 5 ☐ Othar (Specify			green Ceme	,	7/3/97	Berlin	. МГ	
Baltimore,	permit. Peg Department Important: If any Injury o		21. Signature of Funeral Service Licens	100		22. Nama and Add	trass of Facility				
m	SQ III S		V CV Kezze	Bucke		100 W:		urbage			е
	535.0		23a. Part1. Enter the officese, or demp shock, or heart faiture. List only of	lications that caused the	na daath, Do r	not antar tha moda of d	Iliam St.	c or raspiratory ari	VID 218	1	Approximata
4	Physician		shock, or heart-failure. List only o	ona causa on each lina				and the first			Intarvai Batween Onsat and Death
	/Medical		Immediata Ceuse (Final	nnes	Les Und	eliona					1, 5AR
	Examiner		disaasa or condition resulting in death)								19
		Jer		000	1 // A	consequence of):				i	2 Greek
	uted	Examiner	Coguantia the list conditions	b. 700	ua to (or an a	consequance of):				- 1	
Ć.	death certificata be executed e attending physician end of for use as the burial-transit	Exe	Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or Injury	( )	0a 10 (01 a3 a c	onsequance ory.					
68760,	ta be ysicia se bu	Redical	that initiated avents	C	ua to (or as a c	onsequence of):					4
	iffica ig ph	Ped	rasulting In death) Last		(0. 2020					į	
Box	eath cer attendin I for use	Ž		d							
	deat e att	Physician/	Part II. Other significent conditions co	ntributing to death but	not rasulting in	the underlying cause	nivan in Part I	23h. Did to	obacco use co	atribute to	the cause of death?
P.0	thet the de ned by the s detached t	hys				the anountying occour	givani in raini i		es 2□No	Prot	
	es the igned be del	by P								N.	ALDI, VIII OIII (IVIII)
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ō	Phys rald	- To	1 ☐ Yas 2 ☐ No  27. Manylar of Death	1 Dinpatiant 28a. Data of Injury	2 DER/Out	patient ob box	4 Littuising I	lome 5 ☐ Rasid			1)
on	Attending or deeth. ector: After by the fune	tou	16 Naturel 5 ☐ Panding	(Month, Day		njury W	ork? □Yas 2□No	200. Dasgribs II	ow injury occurr	90	
S	deet deet ctor: y the	Ca	3 ☐ Suicida 6 ☐ Could not ba	28e Place of Injury	. At home for	rm, straat, factory, offic		28f. Location (S	treet and Numb	er or Rura	I Route Number
Division	or A efter Direct	Certification:	4 ☐ Homicida datarmined	building, atc.	(Specify)	m, stidat, lactory, onto		City or Tow		o, o, riaia	Troda Trombon
	pital ours eral fille		29a, Certifiar Certifying Phy	elclen: To the best of	my knowlodge	, daeth occurred at tha	time, data and place	and due to the o	ouge(s) and ma	2222222	ated
	To the Hospital or Attending Physician: within 24 hours effer deeth.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Madical Exami	ner: On the besis of a	kamination and	for invastigation, in my	opinion, daath occu	urred at tha tima, d	lata and place,	and dua to	tha causa(s)
	ithin mpl	8	29b. Signature and title of certifier		7>	29c. Lica	nsa number	. 2	9d. Date signed	L/Month.	Dav. Yaar)
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_					Ce	rtificate of	Death	, ,	eg. No.		
П	Physic	ion	1. Decedent's Name (First, Middle, L	,				2. Dete of Deet Month		3. Time of Deep	th
	Physic /Medi		Ralph H	. Story				June 1	18, 199	7 10:45	P.M.
Š.	Exami		4e. Fecility Neme (If not institution, g	ve street and number)			4b. City, Town, or L	ocation of Death	4c. County of	Deeth	
1			Prince George's	General Hospi	ital		Cheverl	У	Princ	e George's	
	Funeral Director		231 32 3372	Sex 7. Age (In y	rs. last birthday Yrs.	if Under 1 Year Months Deys		8. Date of Birth (Month, Day, Aug. 31	Year) ,1924	9. Birthpiace (Stete or For Country) Virginia	veign
	pu *		Usuel Residence of Decedent  10e. State 10b. County	100	City, Town or L	noation				40d tastds Oib. Li	landa a
	8a-f sho	ector	Maryland Prince		Bowie					10d. Inside City Li	
	23a or 2	Funeral Director	10e. Street end Number 2812 Federal Lar	ie		10f. Zip Code	20715	10	Og. Citizen of Wr United	States	
0200	s 1 end 2 should be filed within 72 hours effer death with the Maryland if Heelth and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Meritel Stetus  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  MXYes 2 □ No If Yes, Give Yeer or Detes: WWI		Was Decedent of If Yes, specify Cub	Hispanic Orlgin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		American indian, White, etc.  White	>
5-0	72 h	etec	15. Decedent's I (Specify only highest g	ducation rede completed)	16a. Dece	dent's Usuel Occu	petion during most of world)	kina	16b. Kind of Bus	iness/Industry	
21215-0020	d within giene. r then "	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		enter	d)	and a	Unior	1	
	othe vent	Bec	17. Fether's Name (First, Middle, Las	t)			18. Mother's Nem	ne (First, Middle, N	Maiden Sumeme,		
Maryland	Aenta Aenta rked rice	To	Alphens Story				Fannie	Clore			
ary	short and a		19e. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Stree	t end Number or Ru	ral Route Number,	City or Town, S	tate, Zip Code)	
Baltimore, M	Health Health Jem 27		Ralph W. Story  20e. Method of Disposition  1 ☑ Buriel 2 ☐ Cremation 3	Son 206	1310 Placa of Disponentery, cre	O Bowie  position (Neme of metory or other ple	Station C	ourt Boy 2, Dele 997	wie Mary 20c. Location - C	71and 20715 ity or Town, State	
i	Pag ment mnt: i		4 Donation 5 Other (Spec							sylvania Co.	. Va
Balt	permit. Pages Department of Important: If II any injury or once.		21. Signeture of Funeral Service Lice	Selen	_ 2		ess of Facility Evans Finapolis F				
	Physician		23e. Part1. Enter the diseese, or cor shock, or heart failure. List only	nplicetion that caused the devone curins on each line.	eeth. Do not en	ter the mode of dy	ng, such es cardiac	or respiratory erre	est,	Approximete Intervel Between Onset end Death	n th
1	/Medical Examiner		immediete Ceuse (Final diseese or condition resulting In death)	e. MYOCAR	DIAL	INFARCTIO	N			2 DAYS	
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	al-trar	хаг	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events	Due to	(or es e conse	quence of):					
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ox 68760,	certificate be executed ding physician end use es the buriel-transit	Physician/Medical Examiner	resulting in deeth) Lest	Due to	(or es e consec	quence of):					
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, P.O.	that the de ed by the deteched		Pert ii. Other significant conditions	contributing to death but not r	esulting in the L	inderlying cause gi	ven in Part I.			ribute to the cause of de B⊡ Probably 4127Únki	
Records,	The lew requires that the deeth cerste has been signed by the ettendire page 2 should be deteched for use	Completed by						24e. Wes er perform		24b. Were eutopsy findin aveileble prior to completion of cause of deeth?	
<u> </u>	The le	Š						1 ☐ Ye	s 200No	1 ☐ Yes 2 ☐ No	
Vital		Be	25. Was case referred to medical				26. Place of Dee	th (Check only one	9)		
>	20 to 15	To	examiner? 1 ☑ Yes 2 ☐ No	Hospitel: 1 Impatient 2	☐ ER/Outpatie	nt 3 DOA Ot	her: 4 Nursing H	ome 5 Reside	nce 6 Other	(Specify)	
ion of	Attending Phy in death.  Sector: After this by the funeral of		27. Menner of Deeth 1 Maturel 5 ☐ Pending 2 ☐ Accident investigetic	28e. Dete of Injury (Month, Dey Year)	28b. Time of injury	Wo	ry et rk? ] Yes 2 □ No	28d. Describe ho	w injury occurred	1	
Division	i or Attending effer death. Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined		home, farm, st	reet, factory, office		28f. Location (Str. City or Town		or Rural Route Number,	
	To the Hospital or Att within 24 hours effer d to the Funeral Direct completely filled in by	Medical C	(Check only 2 Medical Exa	nysicien: To the best of my k miner: On the basis of exami end manner steted.	nowledge, deet nation end/or in	vestigation, In my	opinion, death occur	rred et the time, da	ate end place, en	d due to the cause(s)	
	200		29b. Signeture end title of certifier	D MO		29c. Licen				(Month, Day, Year)	
	(00)11	1	· mutt				10343		JUNE	19, 1997	
(	20/	la	30. Name end eddress of person who 3231 SUPERIOR	LANE A-6	, BOW	E , MAI	RYLAND	20715			
	Sta Registr	_	31. Date filed (Month, Dey, Year)	Registrer's Sig	natur						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month JR. L. STONE, June 19, 1997 10:10 A.M. 4e. Fecility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Bowie Health Care Center Prince Georges Bowie If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) X 🖾 M 2□ F Days Yrs. Feb. 8, 1937 243 48 3513 60 North Carolina Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits Prince George's Nes 2 No Bowie 10f. Zip Code 10g. Citizen of Whet Country? 12402 Shelter Lane 20715 United States 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 1 ☐ Yes 2☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) Department of Supervisor Defense 17. Father's Neme (First, Middle, Last). 18. Mother's Neme (First, Middle, Maiden Surname) Hunter L. Stone Wilna Dick 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Barbara L. Stone Wife 12402 Shelter Lane Bowie Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 Dother (Specify) Metropolitan Crematory June 20,1997 Alexandria, Va ure of Fungral Service Licens 22. Name and Address of Fecility
Evans Funeral Home Inc 16000 Annapolis Rd Bowie, Md 20715 23a. Pert1. Enter the disease, or compileators that crused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on yoch line. Approximate Intervel Betw Onset end Deeth Accelerated allewoschians Immediate Cause (Final MausMandatian Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Ursa 6 mo failur 6 wo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 BNo 3 Probably 4 Unknown Panematic pseudoapst 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpetient 3 ☐ DOA 28c. Injury et Work? 28e. Date of Injury (Month, Day Yeer) 28d. Describe how Injury occurred 28b. Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. aminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed, (Month, Day, Yeer) D18010 91

permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural". A many Injury or other traumetic event. **Physician** Examiner Box 68760. Division of Vital Records, P.O.

physician end the burial-transit 80 ettanding signed by the ettar **D**990 cartificate this funeral i or Attending P after death. Director: After t filled in by the

**Physician** 

/Medical

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Marical Examiner must be notified at

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Certification:

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11. Marital Status

diseese or condition resulting in death)

examiner? 1 Yes 2 No

27. Manner of Deeth

1 Naturel

2 Accident

3 Suicide

296. Certifie

29b. Signal

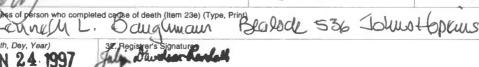
4 Homicide

10e. Street end Number

To the Hospital o within 24 hours at To the Funeral D pletaly

State Registrar

31. Date filed (Month, Dey, Year) JUN 24 1997



The same of the sa

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 2 | | 20 State of Maryland / Department of Health and Mental Hygiene

Iteml 7-1	5-9	77 FilmG749 W.H.Per Doc	tor		Certificate of	f Death	Reg.	No.		
Dharaisi		Decedent's Name (First, Middle, Las Albert Lee	st)				2. Dete of Deeth		Vaar	3. Time of Death
Physici /Medi		Albertson	St. C	lair				Day 19	Yeer 997	7:30 a.m
Examir		4a. Facility Neme (If not institution, give	e street end number)			4b. City, Town, or Lo		4c. County	of Deeth	7.20 0.111
		5402 Morton Plac	e			Riverdale		Prince	e Geo	rge's
Funeral		Social Security Number     6. S		(In yrs. lest bir	rthday) If Under 1 Yea Months Dey		8. Date of Birth (Month, Dey, Ye			ece (State or Foreign
Director		216-30-2573	<b>⊠</b> M 2□F	63	Yrs.	5 110015 141111.	Oct. 14,	1933	Vashi	ngton, DC
>		Usual Residence of Decedent  10a. State 10b. County		10- 0'r- T-						
shor	-			10c. City, Tow					10	Od. Inside City Limits
Page 1	cto	Maryland Prince G	eorge's	River	dare					1⊠ Yes 2□ No
O 2	늠	10e. Street end Number			10f. Zip Code			Citizen of W	/het Count	try?
23a	<u>w</u>	5402 Morton Place			2073	7	U.	S.A.		
SE D	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U,S.	13. Was Decedent of	Hispenic Origin? (Spetiben, Mexicen, Puerto	cify Yes or No- Rican, etc.)		- America k, White, e	
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinat must be notified at once.	by F		1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	0	1 ☐ Yes 2 ☒ N			Specify	T.Tl. d	
1	q p	3 ☐ Widowed 4 🖾 Divorced						0,000,000		
and and	lete	15. Decedent's Ed (Specify only highest gre	ucetion de co <i>mpleted)</i>	160.	<ul> <li>Decedent's Usuel Occ (Give kind of work don life. DO NOT use retir</li> </ul>	upetion e during most of worki	ing 16t	. Kind of Bu	siness/Ind	ustry
D P	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	Carpenter			arpen	tor/S	olf
nt, #		17. Fether's Neme (First, Middle, Last)			oarpenter		(First, Middle, Mai			-
D 0 0	Be					100			6)	
metic	2	William Gordon S		401-			izabeth R			
raul traul		19a. Informent's Name/Relationship (7) Daisy P. Stanton			o. Mailing Address <i>(Stree</i> 402 Morton			-		(0737
ther		20a. Method of Disposition	515001		f Disposition (Neme of	Trace, Kiv		Locetion -		
- H 15		1 ⊠ Burial 2 □ Cremation 3 □		cemete	ry, cremetory or other p					
rtant		4 □ Donetion 5 □ Other (Specify		Cedar	Hill Cemet		30/97Su	itland	, Mai	ryland
any ir		21. Signeture of Funeral Service Licen	see A A A	0	22. Name end Add Francis	ress of Fecility Gasch's Son	ns Funera	1 Home	. P.	Α.
		Claudett	e 0. D	asch	4739 Bal	timore Ave	nue, Hyat	tsvil]		
	١.,	23a. Pert1. Enter the disease, or comp shock, or heart failure. List only	olications thet caused tone ceuse on eech line	he death. Do	not enter the mode of dy	ying, such as cardiec o	r respiretory errest,			Approximate Intervel Between
/sician			1	,	1	1	1 (,			Onset end Deeth
edicai miner		Immediate Ceuse (Final disease or condition resulting in deeth)	· (drem	of	Lina With	n (Plotos	1 MOTas	U165	1	north
	J	resulting in deeth)	C	ue to (or es e	consequence of):					
sit	Examiner		b							
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attendir for use	clan									
ched	Physician/	Part II. Other eignificent conditions co	entributing to death but	not resulting in	n the underlying cause g	given in Pert I.	23b. Did tober	co use con	tribute to	the cause of death?
igned by the a							1 ⊈ Yes	2□ No	3 Prob	ably 4 Unknown
og p	d by								04: 111	41- 11
been si	Completed						24e. Wes en e	utopsy !?	eve	re eutopsy findings ilable prior to
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ped	Co						1 (2 yes	2 1 No	1 🗆	Yes 2□ No
s certificate director, pe	Be	25. Was cese referred to medical exeminer?				26. Plece of Deeth	(Check only one)			
this or	ဥ	1 Yes 2 No		2 ☐ ER/Ou	tpatient 3 DOA	ther: 4 Nursing Hor	ne 5 Residence	6 □Othe	r (Specify	)
unera	on:	27. Menner of Death 1 ☐ Neturel 5 ☐ Pending	28e. Dete of Injury (Month, Dey	28b. T	Time of 28c. Injury W	ury et 2 ork?	28d. Describe how i	njury occurre	ed	
or: A	Certification:	2 ☐ Accident investigation			M 1[	Yes 2 No				
n by	E	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plece of Injury building, etc.	y - At home, fe (Specify)	rm, street, factory, office	2	28f. Location (Street City or Town, St	t end Numbe tete)	or Or Rural	Route Number,
2 P										
ely fi	edical	Check only 2 Medical Exami	sicien: To the best of iner: On the besis of e	my knowledge	, deeth occurred et the t d/or investigation, in my	time, dete end place, a	nd due to the ceus	e(s) end mer	nner es ste	eted.
To the Funeral Director: After completely filled in by the funer	Med	Grief	end menner state	ed.						
<b>₽</b> 8	~	29b. Signeture end title of certifier	( Valillan)			nse number	29d.	Date signed	(Month, D	Pay, Yeer)
7		Weden/11 +	A MILLIAN		1	10226	Ju	ne 25,	199	7
/		30. Neme end eddress of person who	ompleted ceuse of dee	oth (Item 23e) (	(Type, Print)					
		Frederick H. Will		5807	Annapolis I	Road, Hyati	tsville,	Mary1a	nd 2	0784-1201
Sta	te	31. Dete filed (Month, Day, Yeer)	32. Registra	s Signeture	. 0. 11					
Registra	ar	JUN 27 199	100000	CULTACIO	TO BE AND					

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State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** Month SMALLEY. BOOKER THOMAS June 1997 4:23pm /Medical 4a. Facility Neme (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Physicians Memorial Hospital La Plata Charles If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthpiece (Stata or Foreign Country) **Funeral** 1☑M 2□F Months Yrs Director 93 227 225 989 Mar. 6, 1904 Lincoln Co., GA Usual Rasidence of Decedent tha Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23e or 28e-f ehow the Medical Examiner must be notified at Director 1 Yas 2 □ No District of Columbia Washington 10a. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? 4206 East Capitol Street, N. E. 20019 United States Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ဩNo If Yas, Giva Year or Detas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Ricen, etc.) 14. Race - American Indian, Black, Whita, etc. 1 Never Married 2 Merrled Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedent's Educetion (Specify only highast grada completed) 16b. Kind of Businass/Industry filed within Hygiana. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pagas 1 and 2 should be filled with Department of Health and Mental Hygian. Important: If Item 27 is marked other that any Injury or other traumetts. Government/Self Employed 5+ Retired Lawyer 17. Fether's Neme (First, Middla, Last) 18. Mother's Nama (First, Middla, Malden Sumema) Be Lula Thomas Ulyssis Smalley 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code) Booker T. Smalley, Jr. - Son 4213 Sandwich Circle, Waldorf, Maryland 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Lincoln Cemetery 7/1/97 | Brentwood, Maryland 21. Signature of Europe Ser 22. Nama and Address of Facility
STEWART FUNERAL HOME, Inc. 4001 Benning Road, N. E., Washington, D. C. 23a. Part 1. Entar the disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such es cardiac or raspiratory arrest, shock, or heart feilura. List only ona causa on aach line. Approximate interval Batwa Onset and Death **Physician** /Medical Immediata Ceusa (Final weeks diseasa or condition rasulting in death) Examiner Examiner failure The law requires that the death cartificate be executed Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseese or injury that initiated events rasulting in death) Last Booker Smalley  $S_c$  Division of Vital Records, P.O. Box 68760, attanding physician for use as the burie Physician/Medical been signed by tha should be datached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Wara autopsy findings available prior to 24e. Wes en eutopsy performed? completion of ceuse of death? cartificata has To the Hospital or Attending Physician: The Willing 24 hours after death.

To the Financial Director. 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 2 1 Yes 2 No 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28b. Tima of 28d. Describe how injury occurred 1 Natural 5 Panding invastigation 1 Yas 2 No 2 Accident 3 Suicida 6 Could not be datermined 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 ☐ Homleide Certifying Physician: To the best of my knowladge, deeth occurred at the time, dete end place, and dua to the cause(s) end manner as stated.

| Medical Examiner: On the basis of axaminetion end/or invastigation, in my opinion, daeth occurred at the time, data and place, and dua to the cause(s) and mennar stated. edicai 29e. Certifian (Check only 29b. Signatura and title of certified 29d. Data signed (Month, Day, Year) 30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print)

Ashraf M. Meelu, MD Southern Maryland Oncology, #2 St. Patrick Drive, Waldorf, Maryland 20603

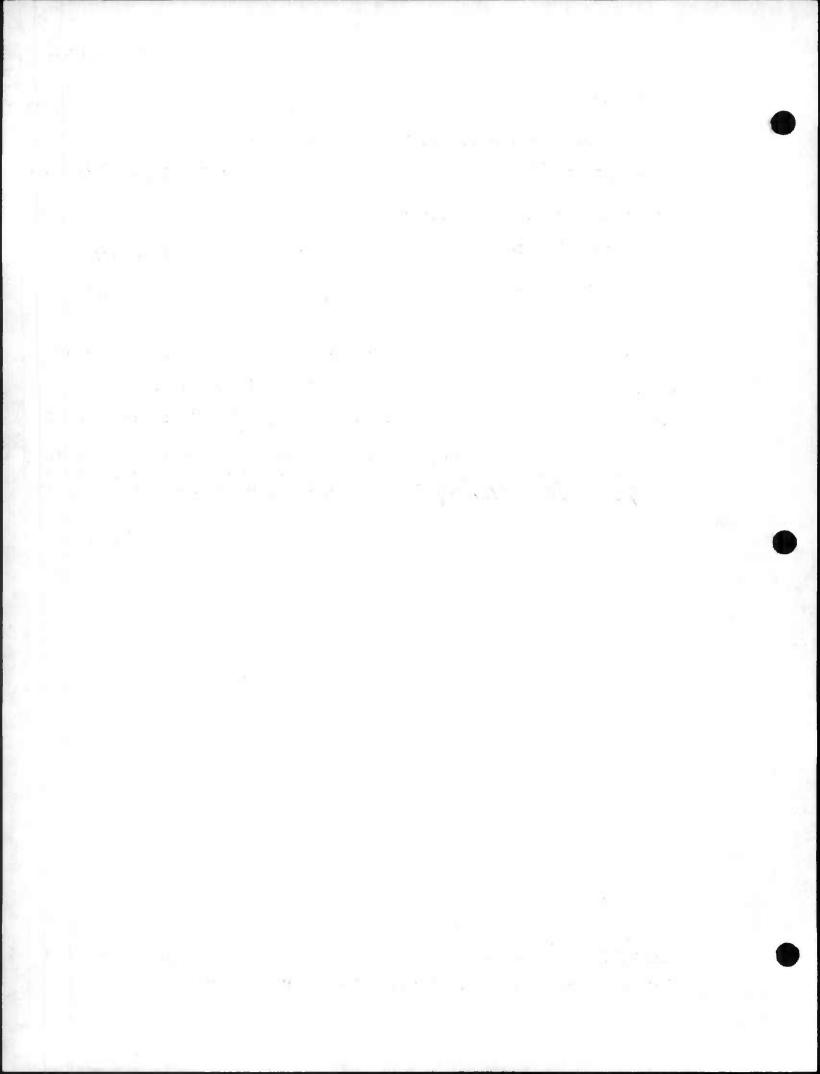
32. Registrads Signetura

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31. Dete fliad (Month, Day, Yaar)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible,
State of Maryland / Department of Health and Mental Hygiene 2 1 1 2 2

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Immediate Causa (Final disaasa or condition resulting in death)  e. Vertical banded gashs planty - Gahic leakage.  Due to (or as a consequence of):	Approximata Intarval Batween Onsat and Death
Sequentially list conditions, if any, laading to immadiate cause. Enter Undartying Cause, Objects of the state of the stat	6
e of the polyphological part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use 1   Yes 2	use contributa to the cause of deeth?
1 Yes 2 The factor of the fact	No 3□ Probably ¾∰Unknown
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1	sy 24b. Wara autopsy findings available prior to complation of causa of death?
1   Yas 2   Yas   1   Yas 2   Yas   1   Yas 2   Yas	1 □ Yas 2 □ No
1 Yas 2 Property of the state o	
25. Was casa referred to medical axaminar?  1	
28a. Data of Injury - At homa, farm, straat, factory, office  27. Mannar of Death  1 Naturel  28d. Data of Injury - At homa, farm, straat, factory, office  28d. Dascribe how injury of Injury at Work?  28d. Dascribe how injury at Work?  28d. Dascribe how injury at Work?  28d. Dascribe how in	
2 Accidant 3 Suicide 4 Homicida  28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)  28f. Location (Straat and Injury - At homa, farm, straat, factory, office building, atc. (Specify)	Number or Rural Route Number,
29a. Certifying Physician: To tha bast of my knowladga, daath occurred at the tima, data and plece, end due to the causa(s) are constructed by the construction of the causa (s) are constructe	ind mennar as statad. place, and due to the causa(s)
\$ 1	signad (Month, Day, Year)
1028639	20 1667
30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print)	une 28, 1997
Jacques Zephirin, MD 2955 Crain Hwy St F, Waldorf, Md	
State Registrar  31. Data filed (Month, Day, Yaar)  32. Registras Signature  Reduction Revolution	l



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day **Physician** Vivian Tyler 4a. Fecility Neme (It not institution, give street end number) June 26, 1997 1:40 A.M. /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Alice Byrd Tawes Nursing Home 201 Hall Hyw. Crisfield, MD Somerset If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Deys Hours Min. 8. Date of Birth
(Month, Dey, Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Deys 1□ M 2🕱 F 86 217-09-5271 Director Maryland Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28s4 show any injury or other traumatic event, the Medical Examinar 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Director Maryland Somerset Crisfield 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 70 Somers Cove Apts. 21817 USA Funerai Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🛣 No þ Specify: White 3 X Widowed 4 □ Divorcad Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Day Care Center Owner 11 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Charles Lewis Nellie Howard 2 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 26835 Roland Tyler Rd. - Crisfield, MD 21817 Della Corbin (daughter) 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Buriel 2 □ Cremetion 3 □ Removal from State Mariners Church Cemetery 6/29/97 4 ☐ Donetion 5 ☐ Other (Specify) Crisfield, MD 22. Name and Address of Fecility Bradshaw & Sons Funeral Home 21. Signeture of Fineral Service License Karluns. 306 W. Main St. - Crisfield. Robert H. Bradshaw MD 21817 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in death) Examiner The lew requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, ettending physician for use es the burie Physician/Medicai Due to (or es e consequenca of): Part II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? id be detect 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? page 2 s this certificate nema 1 ☐ Yes 2 ☐ No 1 ∏ Yes 2 □ No the Hospital or Attending Physician: director. 25. Wes case referred to medical examiner? 28. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4M Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 2 1 ☐ Yes 2 No funeral 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how Injury occurred After 28c. Injury et Work? 5 Pending investigation 1 Naturel death. 1 Yes 2 No 2 Accident Director: / 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) efter 4 Homicide To the Hospital o within 24 hours eff To the Funeral Di completely filled in Medical 156 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated. 29e. Certifier (Check only one) 29b. Signature end title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) recio Name end eddress of person who completed cause of death (Item 23e) (Type, Print) GREGORIO M. BELLOSO, MD. 5302 CHINABERRY DR., SALISBURY, MD 21801

State Registrar 31. Date filed (Month, Day, Yeer)

32. Registrer's Signeture

who Saviles Rardall JUN 3 0 1997

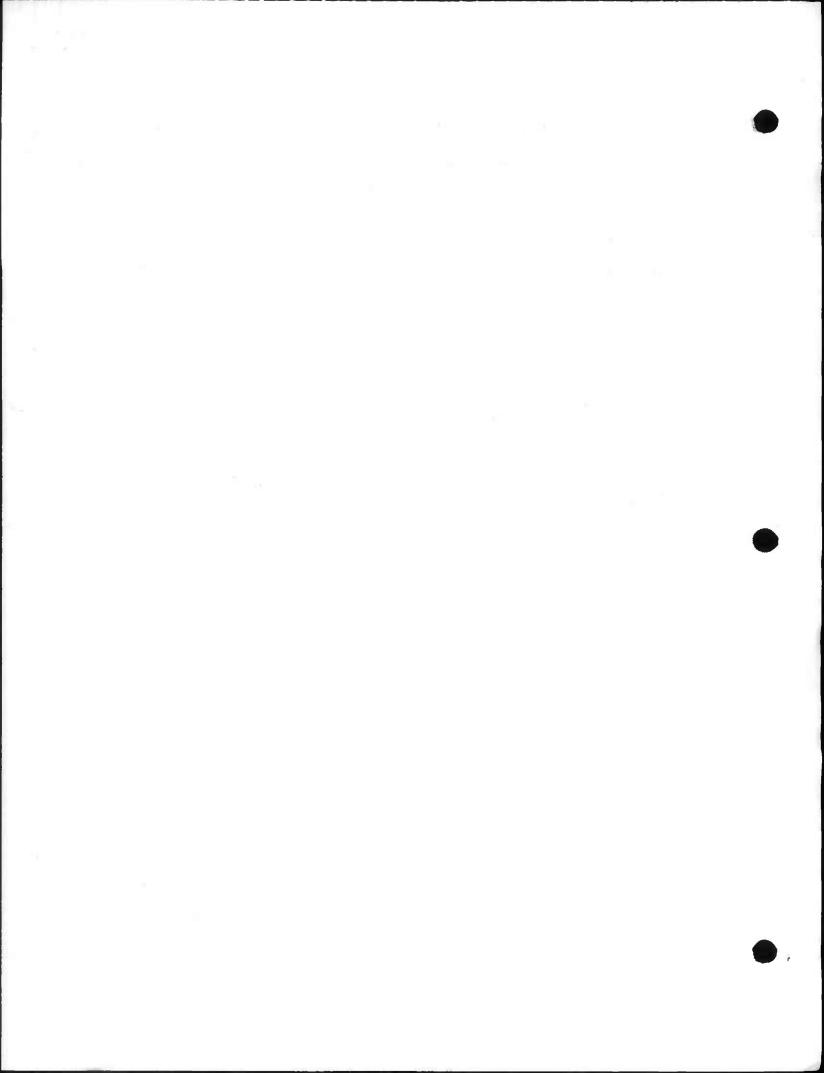
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed wirth. Jours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled written by burial transfer death with the State float of Health and Manyal Hunisian point to burial transfer of the state float that the State float the state float that the State float of Health and Manyal Hunisian point to burial transfer of the state float that the State float the state float that the State float the state float that the state float that the State float that the State float that the state float the state float the state float that the state float that the state float that the state float that the state float that the state float that th BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR

#### STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

_	_	REGISTRAR		CERTI	FICALE	: Or	DEATH	REG. NO	).					
	i	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH	. TIME OF DEATH					
		SARAH SUT	HERLAND 1	TAYLOR				June 20.	1997	YEAR	7:00 A.M			
	1	4. SOCIAL SECURITY NUMBER		) IF UNDER	4 4540	IF UNDER 24 HRS.	7. DATE OF BIRTH	1337						
	1			In yrs. last birthda	MONTHS	DAYS	HOURS MIN.	(Month, Day, Year)		Country)	ACE (State or Foreign			
-		131-28-1714	1 M 2 F E	8 YRS				July 16.	1938	New \	/ork			
	ľ	9e. FACILITY NAME (If not institution, give st	reet and number)		9b. CITY,	TOWN C	R LOCATION OF DE	EATH		TY OF DEA				
- 19	בַ	23621 Cemetery Ro	ad		Cha									
l i	S CH	23621 Cemetery Road Chance Somerset												
1	1	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY												
	DIME	M 1								- 1	LIMITS?			
		Maryland Somerset Chance 1 □ yes 2 No 100. STREET AND NUMBER 101. ZIP CODE 109. CITIZEN OF WHAT COUNTRY?												
- 13	A	106. STREET AND NUMBER				101	ZIP CODE		10g. CITI	ZEN OF WH	AT COUNTRY?			
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		IF YES CIVE WAR OR DATES												
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9	ا د	15. DECEDENT'S EDUCATION 160. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY												
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at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)	A = = = = = = = = = = = = = = = = = = =				18. MOTHER'S NA	ME (First, Middle, Maiden	Surname)					
<u>8</u>	۱۱ ا													
2 2	וום	WILLIAM ROGERS  HELEN ROGERS  196. INFORMANT'S NAME (Type/Print)  196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
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ts s		20e. METHOD OF DISPOSITION 1   Burlel 2 Cremetion 3 Remo	20b	PLACE AND DAT	E OF DISPOS	TION /Na	me of	DATE 20c. LC	CATION —	City or Town	, State			
E		4 Donetion 5 Other (Specify)	SA SA	etery, crematory o	CRFM	ΔΤΩΕ	2V	6/23/97	SALT	CRIIDV	MD			
medical examiner must be notified		4 Donetlon 5 Other (Specify) SALISBURY CREMATORY 6/23/97 SALISBURY MD.  21. SIGNATURE OF PONENAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY												
Ē	ì	HINMAN FUNERAL HOME 21853												
, S		11673 SOMERSET AVE. PRINCESS ANNE. MD.												
medical		23. PART / Enter the diseases, or c	omplications that caused	tha death. Do	not antar	tha mo	da of dylng, suc	h as cardiac or read	Iratory arr	est Alviv	Approximata			
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other traumatic event, the		DUE TO (OR AS A CONSEQUENCE OF):												
2 2	.	disease or condition a. CORNARY OCCLUSION MINUTES  DUE TO (OR AS A CONSEQUENCE OF):  UNCONTROLLED DIABETER MELLITUS 4/18												
E S	2	Sequentially list conditions, If any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):												
trau	7	cause. Enter UNDERLYING												
5 5	2	CAUSE (Disease or Injury C.												
jury, or other	1	that initiated events  DUE TO (OR AS A CONSEQUENCE OF):  reaulting in death) LAST												
ry, or other traumatic	5 1	d												
		PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY FINDINGS												
= 3	ŧ 1	PART II. Other significant conditions	a contributing to death b	ut not rasultin	In the un	derlying	causa givan in				ERE AUTOPSY FINDINGS			
an S	: MEDICAL	PERFORMED? AVAILABLE PRIOR TO  COMPLETION OF CAUSE OF DEATH?  OF DEATH?												
90									100		F DEATH?			
		DID TORACCO LICE CONTRIBUTE TO CALIFE OF DETAIL AND TO AN ACCOUNT.												
13		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN												
item	5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE DF DE	OTHER									
or item	2	1 TYES 2 NO	1 Inpetient 2 ER/Outp	8 Other (Specify)										
5		27. MANNER OF DEATH  28a. DATE OF INJURY  28b. TIME OF  28c. INJURY AT  28d. DESCRIBE HOW INJURY OCCUR												
marked,		1 Natural 5 Pending	(Month, Day, Year)		NJURY	1 V	RK? ES 2 NO							
s marked	5	2 Accident Investigation												
	9	3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Spec	- At nome, tarn	, street, lecto	ory, office		28f. LOCATION (Street City or Town, State,	LOCATION (Street and Number or Rural Route Number, City or Town, State)					
1 28 H		4 Homicide determined												
If Item 2	i	29a. CERTIFIER (Check only  1 **CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) end menner se stated.												
2 = 3														
NA C	3 1	One) 2 MEDICAL EXAMINER: On the beals of axamination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner as stated.												
5 E   u	ıll	296. SIGNATURE AND TITLE OF CENTIFIER 29d. DATE SIGNED (Month Day, Year)												
2 X	1	DOLT56 > 6/23/97												
S ≥ C	2	30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)												
	H	W.												
	Jesus G. Santiano M.D. 100 8th Street Pocomoke City.										851			
	31. DATE FILED (Month, Day, Year)  32. DEGISTRAN'S SIGNATURED JULIA D'AUMENT TOTAL													
		ST. DATE PILED (MONTH, Day, Year)	7 32 7 31 7 7 3 3147	ner had all										



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible 1 1 2 5 State of Maryland / Department of Health and Mental Hygiene

						Ce	rtificat	e oi	f Death			Reg. No.			
	•	П	1. Decedent's Name (First, Middle, La	rst)							2. Dete of D	eeth		3. Time	of Death
Physicia			Mildred T. Th	masi	M						Manth	Dev	agg	0	721
	edica		4a. Fecility Neme (If not institution, gir						4b. City. To	wn. or Lo	ocation of Dee	th 4c Cou	nty of Deeth		1000
Exai	mine	er													
			MedPointe Contin  5. Social Security Number 6.5	uing Ca Sex	_	CILITY n yrs. lest birthday	If Under	1 Yea	E1k		9 Date of B		ecil	-1 (01	
Funei				1  M 2	7. Age (II	77 Yrs.	Months	Dey		Min.	8. Dete of Bi (Month, D	ey, Year)		piece (Stat ntry)	
Direct	tor		Usual Residence of Decedent		l	77					12-29-	-19	Wilm	ingto	n, Di
and w.	.		10e. State 10b. County		10	c. City, Town or L	ocation							10d. Inside	City Limit
fary		5	Delaware New Coatle										es 2 🖾 N		
h the Maryland r 28a-f show		ec e	10e. Street end Number				406 75	01				40 000	4110		
death with the Maryland ms 23a or 28a-f show		합					10f. Zip					10g. Citizen	or whet Cou	ntry?	
ath w		8	2213 South Colleg			19702							US		
		Funeral Director	11. Maritel Status  12. Wes Decedent Ever in U,S. Armed Forces?  13. Wes Decedent of Hispenic Origin? If Yes, specify Cuban, Mexican, Pu						igin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	Raca - Ameri Bieck, White,		,		
72 hours after natural", or its			1 ☐ Never Married 2 ☐ Married	2 XNo	No 1 ☐ Yes 2 ☒ No Specifi						Specify: White				
ours leaf,		ρ											ony.		
within 72 hours ene. than "natural",		Completed	15. Decedent's E (Specify only highest gro	ducation	1	16a. Decedent's Usuai Occupation (Give kind of work done during most of w					rina	16b. Kind o	f Business/In	ndustry	
within ene.		힐	Elamantary/Secondary (0-12)	Coilaga (		life.	DO NOT us	se retir	red)						
filed with Hygiene. other than		ò	2 Homemaker								Own H	Own Home			
S S S S S S S S S S S S S S S S S S S		Be							er's Name	e (First, Middle	, Meiden Sun	Sumeme)			
should be filed and Mental Hygi marked other umatic event,		2	Chester R. Jones						Beat	rice	King				
2 sho end l	l'		19e. informent's Name/Reletionship (	Type, Print)		19b. Mail	ing Address	(Stree	et end Numb	er or Run	al Route Numi	ber, City or To	vn, Stete, Zi	o Code)	
end 2 salth e			Charles E. Thomps	on, Jr.		2213	South	Co	ollege	Ave	nue, Ne	wark,	DE 19	9702	
s 1 end 2 should be filed within 72 ho if Health end Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical		ľ	20e. Method of Disposition		2	Ob. Plece of Disp	osition (Nen	ne of			Dete		on - City or T	own, State	
Pages nent of P int: If Ite			1 ☑ Burial 2 ☐ Cremetion 3 ☐			Gracelaw		٠.		י עיי	7-2-97	Nov. C	20+10	Dol	2112 10
permit. Pages 1 end 2. Department of Health el important: if Item 27 is any injury or other trau			4 Donetion 5 Other (Special	1							7-2-37	Mew C	astle	, Del	awar
Depa mpo my I	DUC.		21. Signature of Funeral Service Lice	1000					ress of Fecili ⊇moria		rvices				
4024	4		and the	2							Newark	c, DE	19702		
		Ī	23e. Pert1. Enter the disease of com- shock, or heart feilure. List only	plications thet o	caused the	deeth. Do not en	ter the mod	e of dy	ylng, such es	cardiec	or respiratory	errest,	1	Approxim	nete
Physicia	an			7			-	Α.					1	Onset er	nd Death
/Medic	_		Immediate Ceuse (Finei disease or condition	/ 1	en	al 5	Fai	11	1-0				1	10	
Examin	er		rasulting in death)	1		to (or es e conse		100						17	V
-		ĕ		0		estive		0_	cut	I	Slee	1/20	1	4.	1115
uted d ansit		Examiner	Constant the flat and distant	b				CC	Cort	10	ulu		1		10
exec n an ial-tr	1	Exa	Sequentielly list conditions, if eny, leading to immediate cause. Enter Undarrying Cause (Disease or Injury that is interested in the Cause (Disease or Injury									1./			
e be sicla		ca	r eny, leading to immediate causa. Enter Underlying cause. Enter Underlying Cause (Disease or Injury the Initiated events								19	V			
intificate be executed ing physician and set the burial-transit	1	edical	resulting in deeth) Lest  Due to (or es e consequence of):												
certi	1	Σ		d											
atter for u		200													
requires thet the death certificate be executed seen signed by the attending physician and hould be detached for use es the burial-transit		Physician/								i.	23b. Did	tobacco uee	contribute t	o the caus	e of deat
het t d by deta	i										1 🗆	Yes 2 N	o 3 Pro	bably 4	Unkno
res t	.	Completed by													Unica di
v require been si should												s en eutopsy omed?	6/	ere eutops reileble prid	or to
ew 2 s t		<u>e</u>												ompletion of deeth?	of cause
The lew ate has b		۱ <u>ع</u>									10	Yes 22 No	, 1	□Yes 2	□ No
			25. Wes case referred to medical						20 Dinos	of Doot	h (Check only				
cent		o Re	examiner?	Hospitai:	Annada - 4	• C = D/O + - 1/-		. 0	ther				الم التي		
Physician: r this certific ral director,		0	27. Manner of Deeth			2 ER/Outpetle					me 5 Res 28d. Describe			ry)	-
Attending in deeth.  actor: After by the funer		<u> </u>	1 ☐ Neturel 5 ☐ Pending		of injury th, Dey Ye	ar) injury		8c. inj	ork?	/	200. 2000.00	now injury oo	,,,,,,,,		
deeth ctor: A y the f		2 Accident investigation M 1 Yes 2 No								-1					
or Attendent efter deetl Director:	1		3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)									ai Houte N	um <i>oer</i> ,		
las las										1					
To the Hospital or Attending Physician: within 24 hours effer deeth.  To the Funeral Director: After this certific completely filled in by the funeral director,		edical	29e. Certifying Ph (Check only 2 Medical Exam	yalcian: To the	best of my	y knowledge, deet	h occurred	et the t	time, dete en	d piece,	end due to tha	causa(s) and	manner as s	stated.	o/e)
Plet Plet		8	one)	and men	ner steted.		ivostigation,		opinion, dea		od ot dio timo,	, dete and piec	0, 0110 000 1	O UIO CAUS	0(0)
T S T S	13	Σ	29b. Signeture and little of certifier	V 0				-	nse number		29d. Date signed (Month, Dey, Year)			Dey, Year	)
			XXIIIIA	N	1		'	Y)4	+319	X					
11-			30. Narrye and address of person who	completed only	in of death	(Item 23a) (Tuna		- (				4/-	1	/	
4				1	/			1	on Mr	) 21	921	/			
	24		James S. Let, M. 31. Date filed (Month, Day, Year)	0. 901/	Warb Registrar's S	urton Ro	au, E.	TKC	OII, ML	, 21	.921				
Regi	State	2	JUL 01 1997												
	-		005 01 133/	grah	David	son-Bandel	Z_								
ALL 46 Day	CADE												* 100		

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					Ce	rtificate d	of Death			Reg. No.				
		1. Decedent's Neme (First, Midd	le, Last)					2	2. Dete of De	eth		3. Time of Deeth		
Physicia: /Medica	_	Alice Derrickson West Trone						J	Month une 2	20, 199	Year	7:00 AM		
Examine	_	4a. Fecility Neme (If not institution					4b. City, Town					7.00 AM		
		103 Park Ci:	rcle				FI	kto	n		eci1			
unerai	П	5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Y	ear If Under 24	Hrs. 8	B. Date of Bir	th		ace (State or Foreig		
irector		216-24-2362	1□ M 2√2 F	91	Yrs.	Months De	eys Hours	Min. N	(Month, De	9, Year) 28, 1905		elaware		
	- 1-	Usuel Residence of Decedent									9 20141141			
athow id at	00	10a. Stete 10b. County 10c. City, Town or Location								100	d. Inside City Limit			
notified	100	Md. Cecil Elkton									YE Yes 2□Ne			
or 28	Director	10e. Street end Number		<u> </u>	10f. Zip Coo	de			10g. Citizen of \	Whet Countr	y?			
		103 Park Cir	ccle	12. Wes Decedent Ever in U,S. 13. Was De			1921			U.S.	7			
Norma Der my	runeral	11. Marital Status					13. Was Decedent of Hispenic Orlgin? (Spilf Yes, specify Cuban, Mexican, Puerto			- 14. Rac	Race - American Indian, Bleck, White, etc.			
		1 Never Married 2 Mar	rled 1 ☐ Yes					delto Hi	oan, etc.,					
- B	D	3 ₩ Widowed 4 Divorced	Year or I				No Specify:			Specin	Whi	te		
olical Ex	Completed	15. Deceder	it's Education st grede completed	1	16e. Deced	ient's Usuai Oc	cupetion one during most o	f working	,	16b. Kind of B	usiness/Indu	istry		
E W	ğ	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use re	tired)	WOIKING	,			7		
E #	0	12	3	3 R∈			red Nur	se		Medi	cal			
· ·	99	17. Fether's Neme (First, Middle,	Last)				18. Mother's	Name (	e (First, Middle, Maiden S		Sumeme)			
aumatic sy	0	Charles Elwo	ood West				Mary	Ma	rgare	t Derr	ickson			
5		19a. Informant's Name/Reletions	ship (Type, Print)		19b. Mailir	ng Address (St	reet end Number							
		Susan R. Tro	ne. Dau	ahter	1.0	3 Dari	- Circi		T 1 1 1 4 4	14-1	2100	2.1		
item 27 other t		20a. Method of Disposition		20b. Pl	aca of Dispo	sition (Neme o	Circ1	e, .	Date	20c. Location	City or Tow	n, State		
= 5		M Buriel 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (5	3 Removel from			natory or other anor N		.6/	24/97	F12+	on h	ма		
ortant: injury 8.	+			Gilpin Manor Mem.										
any and		21. Signature of Farrieral Service Licensed  22. Name end Address of Facility  259 E. Main  Gee Funeral Home Elkton, Md.												
	4	1171-	X								. 213	721		
	1	23a. Part1. Enter the dispase, or shock, or heart failure. List	complications thet only one ceuse on	caused the death eech line.	. Do not ent	er the mode of	dying, such es ca	ırdiac or ı	respiretory e	rrest,	1 1	Approximete Intervel Between		
ician		Onset end Dear												
dical niner		Immediate Ceuse (Final disease or condition resulting in death)  e. Coronay Artery Disease  Due toor as e consequence of):										years		
THE REAL PROPERTY.	- 1	resulting in death)		Due to or	as e consec	uencof):								
Sit.														
physician and stransit street burial-transit	Examme	Sequentially list conditions,		Due to (or	es e consec	uence of):					1			
		if eny, leading to immediate cause. Enter Underlying												
ng physicis s es the bu	200	Ceuse (Disease or injury that initiated events resulting in death) Lest  Due to (or es e consequence of):									1			
9 98	20 2										1			
afor use es	2		d								1			
ed fo	2	Part II. Other elgnificant condition	ons contributing to d	leath but not resu	Iting in the u	nderlying cause	given in Pert I.		23b. Dld	tobacco use co	ntribute to t	the cause of death		
by the	riiysiciain								10	Yes 2□ No	3 Proba	ably 4 dnknow		
be de	2								, ,					
been signed by the ettendi should be detached for us	2								24e. Wes	en eutopsy	24b. Wer	e eutopsy findings		
sho	1								репо	ormed?	com	leble prior to pletion of cause eeth?		
page 2 should														
one Funeral Director: Affer this certificate he completely filled in by the funeral director, page Madinal Certification: To Re Com									10		1 🗆	Yes 2□ No		
director, page 2 s		25. Was case referred to medica examiner?	Hospital:				Othor:		Check only					
al dire		1 Yes 2 No	10		ER/Outpatier					dence 6 □Oth				
led in by the funeral	5	5		27. Manner of Deeth 1 ☑ Natural 5 ☐ Pendir	28e. Date (Mor	of Injury oth, Dey Year)	28b. Time of Injury		njury et Work?		ld. Describe	how injury occur	red	
the f		2 Accident investigation M 1 Yes 2 No												
by Life		3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)  28f. Location (Street e building, etc. (Specify)									d Number or Rurel Route Number,			
i pe	5								_					
To the Funeral Director: After completely filled in by the fune fune Martical Certification	2	29a. Certifier 1 Certifylr	g Physician: To the	e best of my know	riedge, death	occurred et th	e time, date end p	olace, en	d due to the	ceuse(s) end me	enner es ste	ted.		
plete	3	one)	Examiner: On the bear and man	ner stated.	on end/or in	restigation, in n	ny opinion, deeth	occurred	i et the time,	dete end place,	ena aue to t	ne cause(s)		
com		29b. Signeture end title of cartifie				29c. Llc	ense number			29d. Date signe	d (Month, D	ey, Yeer)		
		> Monte my	somo 1	10		D	-4478	3		June	23,1	997		
	1	30. Name end eddress of person		se of death (Item	23e) (Type	Print)								
		MONTE MAK					neet,	ELF	TON.	MD 2	-1921			
State		31. Date filed (Month, Day, Year)		Registrer's Signet										
state Registrar														
		JUN 25 199	Julia	Davidson	Monda Be									
6 Rev 6/95			U											

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							Cer	tificat	e of	Death			Reg. No.		
-1	Physic	an	Decadant's Nama (First, Mid     MAD TE GUICANAC	dla, Last)								2. Data of Da Month	ath Day	Yaar	3. Tima of Death
	/Medi		MARIE THOMAS									JUNE 2	25, 1997		00:45
	Exami		4a. Facility Name (If not instituti	-								ocetion of Daat		ty of Daath	
			Calvert Memor	cial Hospi	tal							rederic	k Ca	lvert	
	<sub>€</sub> Funeral		5. Social Sacurity Numbar 217-36-6763	6. Sax 1 □ M 2 T F		63 vrs. last birt	-	If Undar Months	1 Year Days		24 Hrs. Min.	8. Data of Bir (Month, Re	th ay, Year)	9. Birthr	place (Stata or Foraign of the yland
	Director			10 1/1 24.71		00	rs.					Dec. 2	6, 1933	Mar	yland
	and **		Usual Rasidance of Dacedant 10a. Stata 10b. Coun	ty	10	c. City, Town	or Loc	cation				-		1.	10d. Insida City Limits
	/anyl	ō	Maryland Cal	vert				ngto	.773						1 □ Yas 2 No
	the 1	90	10e. Straat and Number			110		10f. Zip					10g. Citizan of	What Cou	ntry?
	with Sa or	ā	155 Kyler Roa	hd						0639			USA	What ood	nuy :
	leath ms 2%	Funeral Directo	11. Marital Status	12. Was Dao	cedant Eve	r in U.S.	13. V	Vas Daced			nin? (Sp	acify Yas or No		ice - Amaric	cen Indian.
0	fter of the rest	Fur	1 ☐ Navar Marriad 2 🕅 Ma	Armed F arriad 1 ☐ Yes	orcas?						, Puarto	acify Yas or No Rican, etc.)		ack, White,	atc.
Maryland 21215-0020	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by	3 ☐ Widowad 4 ☐ Divorce	If Yes G	iva		1	☐ Yes 2	2 (Z) No	Spacify:			Space	ity: Bla	ck
0-10	in 72 hours "natural", edical Ex	Be Completed	15. Daceda	ant's Education		16a.	Dacad	ant's Usua	I Occu	pation		,	16b. Kind of I	3usinass/In	dustry
215	thin 7	ple	(Specity only night Elementary/Secondary (0-12)	ast grada completed,	(1-4or 5+)		life. D	O NOT us	a ratire	during most ad)	of work	ing			
2	od wi	00	11		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Cu	stod	ian				Apa	rtmen	ts
nd	ai Hy	Be	17. Father's Nama (First, Middle							18. Mothe	r's Nam	a (First, Middle	, Maidan Suma	ma)	
yla	should be nd Mentai marked o	은	James	Owen	Ho11	and				Eth	e1	Glad	dys	Thoma	as
a	permit. Peges 1 end 2 should be filed within Department of Health end Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Mance.		19a. Informant's Name/Ralation										ar, City or Town		Code)
	end ealth n 27		Madeline Jones	S/Sister						St.	Нуа	ttsvil	le, MD	20781	
ore	Peges 1 end 2 nent of Health e ant: If Item 27 is ury or other tra		20a. Method of Disposition  1   Burial 2 □ Cramation	3 □Removal from		Ob. Place of cematary	Dispos , cram	sition (Nan atory or o	na of ther pla	ica)		Date	20c. Location	-	
Ë	Peg ment ant: I		4 □ Donation 5 □ Othar (		Otata	St. Ed	mon	ds U	MC (	Cem.	6	30/97	Chesape	eake !	Beach, MD
Baltimore,	permit. Departr Importa any Inj		21. Signatura of Funaral Servic	a Licensea	0		22.	Nama an	d Addre	ess of Facility	y Se	well F	meral	Home	
Ш	80 = 8 8		Maden	a. Sewel			14	51 Da	ares	Beach					k, MD 20678
			23a. Part1. Entar tha disaase, shock, or heart failura. Lis	or complications that	causad tha	death. Do n	ot anta	r tha mod	a of dyi	ing, such es	cerdiac	or raspiratory a	ırrast,		Approximate Intervel Batwaan
	Physician	6.9													Onsat and Deeth
7	/Medical		Immadiata Causa (Final disaasa or condition	-	モメ	2011	1.6	L	W	eia?	ens!	2il			
ш	Examiner		resulting in death)	a	Due	to (or es e c	onsaqı	uance of):				^			
	pe #	ine		<b>a</b> b	70 3	01	<	· an	is.	20-	0	40		- 1)	
	certificate be executed iding physician end ise as the buriel-transit	Examiner	Saquantially list conditions, if any, leading to immediate		Dua	to (pras a c	onsequ	ence of):				1		/	
.09	be ed Ician burie		Saquantially list conditions, if any, laading to immediata causa. Entar Undarlying Causa (Disease or injury	<b>c</b>		1.	11	100	262					/-	
68760,	icate phys s the	//Medical	that initiated avants rasulting in daath) Last		Dua	to (or as a co	onsequ	en <i>ce</i> of):							
X		J/M		d											
m	deeth e atten ed for u	Physician										1	/		
P.O.	es that the deeth igned by the atte be deteched for	ıysı	Part II. Other significant condit	ions contributing to d	deeth but no	ot rasulting in	tha un	derlying ca	ausa gi	van in Part I.					tha causa of death?
	that sed b											1 🗆	Yes 200 No	3 □ Pro	bably 4 ☐ Unknown
of Vital Records,	requires that the een signed by th hould be deteche	d by										24a Was	en autopsy	24b. W	ara autopsy findings
00	200	ete										parfo	ormad?	/ co	ailabla prior to mplation of ceuse
Re	e jav hes	Completed											_/		daath?
O	ician: The certificate h rector, page		Or Manual Control									10		1[	☐ Yas 2☐ No
Ξ	Physician: rthis certific rai director,	Be C	25. Was cesa rafarred to medic axaminar?  1 ☐ Yas 2 ☑ No	Hospital:	/			-5	Ott	hor:		h (Check only o			
of	Phys r this eral d	5	27. Manger of Daath	28a. Data	Inpatient of Injury	2 ER/Out			A	4 □ Nui			dance 6 □Ot how injury occu		у)
Division	Attending or death. ector: After by the fune	Certification:	1 Natural 5 Pend 2 Accidant Invas		nth, Day Yea		jury	м	Bc. Injui Wo 1 □	rk? ]Yes 2∐ N			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
S	Atten deal ctor: y the	fica	3 Suicida 6 Could	not be	e of Injury -	At homa, fan	m. stre					28f. Location (	Straat and Num	ber or Rura	al Route Number,
S	after Dire	er	4 Homicide		ling, etc. (S		,	.,,	,			City or To			
	Hospital 24 hours Funeral stely filled	a C	29a. Cartifiar 1 Certify	ng Physician: To the	bast of my	/ knowladga.	daath	occurrad a	at tha tir	ma. data and	d placa.	and dua to the	causa(s) and m	annar es s	tatad
	To the Hospital or Attanding Physician: within 24 hours after death.  To the Funeral Director: After this certification pletely filled in by the funeral director,	edicai	(Check only 2 Medica	i Examinar: On tha b	pasis of axa	mination and	or inve	estigation,	in my c	opinion, daat	h occurr	ad et tha tima,	data and place	, and dua to	the causa(s)
	To the within 2 To the comple	Me	29b. Signatura and Ita of certifi	ar O				29c	. Licens	se number			29d. Data sign	ad (Month,	Day, Year)
			~\l	X				T	10	スヘロ	7		1.33	19:	1
	10	-	30. Name and eddress of parson	who completed care	sa of death	(Itam 23e) /7	Type P	rint)	70	١٥٠١	_		0	1 - 6	1
	10	-	Dr.Issam Da	malouji	M.D.	Prin	ce	Fre	der	ick N	MD :	20678			
	Sta	te	31. Data filad (Month, Day, Year	32. F	Ragistrar's S				1						
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State of Maryland / Department of Health and Mental Hygiene 97 2 1 2 8

						Cer	tificate of	Death		R	eg. No.		
	<b>D</b> 1		1. Decedent's Nama (First, Middla, La							2. Date of Deel	th	Vana	3. Time of Death
ı	Physici /Medi		William	Adrian	7	ate	<del>)</del>			June	20,	1997	18:29
	Examir		4e. Fecility Name (If not institution, given	ve straat and number)				4b. City, To	wn, or Loca	ation of Deeth	4c. G	ounty of Death	
			Calvert Memorial	Hospital				Prince	Fred	erick		Calvert	
Т	Funerai		5. Social Security Number 6.	Sex 7. Age	(In yrs. last bi	rthday)	If Undar 1 Yaa Months Deys	r If Under		B. Dete of Birth (Month, Day)		9. Birth	pleca (State or Foreign
k	Director		578-56-4038	15xm 2□ F	54	Yrs.	Working Doy.	Tiodis		Sep. 8,			ginia
	pu .		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	m or 1 or	ntion			,			
	sho	5	Too. State		Toc. Only, Tov	III OI LOC	AUDIT						10d. Inside City Limits 1 ☐ Yes 2 🗓 No
	he N	Director	Maryland Calvert		Dunk	irk	101 71 0 1	*					
	with a or						10f. Zip Code			1		n of What Cou	ntry?
	s 23	era	4101 Overlook		uas in 11 C	40.14	fa a Danada at at	20754	-i=0./0	4. V N.		S. A.	1
	item Item	Funeral	11. Marital Status	12. Was Decedent E		13. Vi	les Decedent of Yes, specify Cu	ban, Mexican	, Puarto Ri	can, atc.)	14.	Race - Ameri Bleck, White,	
20	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	1 ☐ Naver Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2√5 No If Yas, Give Yeer or Detes:	0	1	☐ Yes 2☐N	Specify:			S	ecity:	
S	tural	8	15. Decedent's E		160	Deced	ent's Usuel Occi	inetion			16h Kind	Whi of Business/Ir	
21215-0020	in 72 "na	Completed	(Specify only highest gr	ade completed)		(Give k	kind of work done O NOT use retir	e during most	of working	7	TOD. KING	OI DUSINESS/II	loustry
212	filed withi Hygiene. ther than ent, the M	E	Elementary/Secondery (0-12)	College (1-4or 5+		moi 14	er Tech	nicol	Encir	2007	TBM		
D	Hyg other	Be C	17. Fether's Nama (First, Middle, Last	")	- 4	шрил	er recr			First, Middle, I		mama)	
Maryland		To B	(Unknown) Tate					Mar	rgaret	Tate			
ary	S D E E	-	19a. Informent's Name/Reletionship	(Type, Print)	198	o. Mailing	Address (Stree				, City or T	own, Stete, Zij	p Code)
	12 and		Marguerite A. Ta	te/Wife	41	.01 (	verlook	Court	Dunl	kirk, M	aryla	and 20	754
ore,			20e. Method of Disposition				ition (Neme of atory or other pl			Date		tion - City or T	own, Stete
Ë	Pages net of nt: if its		1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		Lee C			200/		me 1997	C1	inton	Maryland
Baltimore,	그는무를		21. Signeture of Funeral Service Lice	ns <i>ee</i>	LICC C		Name and Add	ress of Fecility	٧				
m	Depariment of the part of the		14 5 6-A	_		01	0.7.0						ert,P.A.
	_		23e. Pert1. Enter the disease, or com	plications thet caused t	he death. Do		25 So.					land	20736 Approximate
	Physician		shock, or heart failure. List only	one ceuse on each line	).						,		Intervel Between Onset end Deeth
	/Medicai		Immediate Ceusa (Final	00.55	$m_1$								M.AUJET
	Examiner		diseese or condition resulting in deeth)	· ACUTE								i	MINUTES
		Je.		D	oua to (or as e	consaqu	ance or):					1	
	eath certificate be executed attending physician and for use as the burial-transit	Examiner	Sequentially list conditions	b	ue to (or as e	consequ	ience of):						
ó	an ar		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	_									
68760,	ite be nysici	edical	Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest	c	ue to (or es e	consequ	enca of):						
39	ntifica ng ph as th	Med	resulting in deeth) Lest				,					į	
Box	th ce	an/I		d					-				
	0 0 0	sici	Pert II. Other eignificant conditions of	contributing to death but	not resulting I	n tha un	derlying cause g	iven in Pert I.		23b. Did to	bacco us	e contribute t	to the cause of death?
0	t t	Physician/								1 U Y	es 2	No 3□Pro	bably 4/2 Unknown
	es tha igned be de	þ						-					
20	been si should	De le								24e. Wes e		24b. W	ere autopsy findings vailable prior to
Records,	aw Is b	ple	+									of	ompletion of cause deeth?
Ψ	0 5 0	Completed								1 🗆 Ye	s 2/1	No 1	☐Yes 2☐ No
ita		Be (	25. Was case referred to medical examiner?					26. Place	of Deeth (	Check only on	Θ)		
>	\$ 00	To	examiner/ 1  Yes 2  No	Hospital: 1 Inpatient	2 ER/O	utpatient	3□ DOA O	ther: 4 Nu	rsing Home	5 ☐ Reside	enca 6	Other (Speci	fy)
0	ig Pt ter th neral		27. Menner of Death 1	28e. Dete of Injury (Month, Day		Time of	28c. Inj	ury et ork?	28	d. Describe ho	ow injury o	ccurred	
Division of Vital	Attending or death. ector: After by the fune	atlc	2 ☐ Accident investigation	n		,,		Yes 2 1	No				
ž	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		y - At home, fe	erm, stre	et, factory, office	•	28	f. Location (St City or Town	reet end f	lumber or Run	al Route Number,
	ital or al Dir led in												
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral	edicai	(Check only	yeician: To the best of niner: On the basis of e	my knowledge	e, death	occurred et the t	time, date end	d place, en	d due to the ca	ause(s) en	d menner es s	steted.
	To the P within 2. To the F complete	Med	one)	and manner state	ed.								
	5 × 5 0		29b. Signature and titlit of certifier					nse number	~	2	9d. Date s	igned (Month,	Day, Year)
e .			W /				Di	2965	/	Ju	WEO/	21/9	7
			30. Name and address of purson who				,				-	,	
			Charles jud	ge 120 H		l Ro	ad #200	Princ	e Fre	derick	, Mar	yland	20678
	Sta	te	31. Data filed (Month, Day, Year)	32. Registrar		0	0.00						
	Registr	ar	9011 A	4 1997 Dei	in someon	works	tolk .						

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State of Maryland / Department of Health and Mental Hygiene 2 | 1 | 2 9

					ar y larra r		tificate of	Death		eg. No.		, 64	
	Physici	an	1. Decedent's Neme (First, Middle, L	ast)					2. Date of Deet Month	h Day	Yeer	3. Time of	Death
	/Medi		Gater	Thomas					June 17	, 1997		200	0
1	Examir	er	4e. Fecility Neme (If not institution, g Calvert Memori		L			4b. City, Town, or L Prince F1		4c. County	of Death alver	t	
	₀Funeral Director		220-16-9149	Sex 7. Agr 1 ☑ M 2 □ F	e (In yrs. last b 82	virthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) Jan 18	, Year) 915	9. Birthpla Countr Mar	ce (State o y1and	r Foreign
	rland low		Usual Residence of Decedent  10e. State 10b. County		10c. City, Tov	wn or Loca	ation				100	d. Inside Ci	ty Limits
	Mar.	tor	Maryland Calv	ert		Prin	ce Frede	erick				1 🗆 Yes	2 No
	or 28	Director	10e. Street end Number				10f. Zip Code		1	Og. Citizen of V		y?	
	e 23e	erai	330 Arthur King		Transin II O	10.14	20678			USA	e - America	n Indian	
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: if item 27 is marked other than "naturet", or items 23e or 28e-f show shy injury or other treumetic event, the Medical Examinat must be notified at once.	by Funeral	11. Maritel Status  1 □ Never Married 2 □ Marrled  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 Armed Forces? If Yes, Give Year or Detes:			Yes, specify Cub	Hispenic Origin? (Spen, Mexicen, Puerto Specify:	Ricen, etc.)		k, White, et	c.	
5-0	72 ho	eted	15. Decedent's I (Specify only highest g	Education rede completed)	166	e. Decede	ent's Usuel Occup	petion during most of work	sina	16b. Kind of Bu	siness/Indu	stry	
121	vithin na. han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		o <i>not</i> use retire borer	during most of work d)		Constr	uctio	n	
<b>d</b> 2	filed v Hygie ther t		17. Father's Name (First, Middle, Las	t)				18. Mother's Nam	e (First, Middle, I	Meiden Sumen	ne)		
/an	fantal fantal ked c	To Be	Louis	Thomas	s, Sr.			Charlott	te		Purve	у	
lary	2 should and A lis man		19a. Informent's Name/Relationship					t end Number or Rui		-		Code)	
≥ ຜົ	and lealth m 27 her tr		Lowell Thomas/Nep	hew			Box 702	Prince 1					
nor	ages Into of H		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3				ition (Neme of etory or other ple & Chr (	Cemetery 6		20c. Location -			D
ätin	eartme ortant injury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	··	30110			ess of Fecility Set				10, 11	
ă	Dapa Impon eny ir		Dladys a			14	51 Dares	s Beach Ro	d. Prin	ce Fred		, MD	20678
			23a. Part1. Enter the diseese, or co- shock, or heert failure. List onl	nplications that caused y one ceuse on eech lir	the deeth. Do	not enter	r the mode of dyi	ng, such es cardiac	or respiratory erro	est,		Approximete ntervel Bet Onset end D	ween
	Physician /Medical		Immediate Ceuse (Finel diseese or condition	Chr	mic	120	nerl	Fairly	ne				
п	Examiner		resulting in death)	е	Due to (or es e		-7					- 4 I	
	be sit	liner	_	b								ney	ear
	ificata be executed g physician and as tha bural-transit	Examiner	Sequentially list conditions, if eny, leading to immediate	-	Due to (or es e	consequ	ence of):						
68760,	a be e /siclar a buri	edicai E	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events	C	Due to (or es e	conseque	ence of):						
-			resulting in death) Lest		2000		J. 100 017.						
Box	ires that the death certif signed by the attanding d be detached for use a	Physician/M		d									
o.	the de	ysic	Pert ii. Other eignificant conditions							bacco use co	11		
<u>ر</u>	s that ned b	by Pt	Cosonam arotes	y disease	- CH	1			1 V	es 2 No	3 2 Probe	ibly 4□	Unknown
Division of Vital Records, P.O.	The law requires that the death cert ata has been signed by tha attandin, paga 2 should be detached for usa	Completed b	Pempheral	y disease Vascu	lon	dis	ease		24e. Wes e perform		com	e eutopsy fi leble prior to pletion of c eeth?	0
Ĕ	Tha la	E O							1 □ Ye	s 2 No	1 🗆	Yes 2	No
/ita		Be	25. Wes case referred to medical examiner?					26. Place of Deat	th (Check only on	e)			•
)	hysic this ca	10	1□ Yes 2XNo	Hospital: 1 Inpatie			3LI DOA		ome 5 Reside	-			
U <sub>C</sub>	ding P. Aftar funari	tion:	27. Menner of Deeth  1 X Natural 5 ☐ Pending investigati	28e. Dete of Injur (Month, De)	Yea <i>r</i> ) 28b.	Time of Injury	28c. Inju Wo	ryet rk?  Yes 2 □ No	28d. Describe ho	w Injury occur	red		
/ISI	or Attending Physicien: after death. Director: After this cartific. I in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not	28e. Place of Inju	ıry - At home, f	ferm, stree			28f. Location (St	reet end Numb	er or Rurel	Route Num	ber,
á	s afte	Cert	4 Homicide	building, etc	c. (Specify)				City or Towr	n, Stete)			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29e. Certifier (Check only one)  CertifyIng P	hyelcien: To the best of miner: On the basis of and menner sta	examinetion a	je, deeth o nd/or Inve	occurred et the ti estigation, in my	me, dete end plece, opinion, death occur	end due to the cared et the time, da	ause(s) end me ate end place,	enner es ste end due to t	ted. he ceuse(s	)
	To the To the comple	¥	29b. Signature and title of certifier	\ 1	220		29c. Licens	se number	. 2	9d. Date signe	d (Month, D	ey, Yeer)	
			) dam	nyonon	m	_M	n D3	1189		4	18/9	7	
	10		30. Neme end eddress of person who	completed cause of course	eath (tuem 23e)	Po	Box	1289/n	ALDOR	F, MD	. 3	060	4
	Sta Registr		31. Date filed (Month, Day, Year)	9 1997 July 1	L's Signeture	bork	ardall						

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State of Maryland / Department of Health and Mental Hygiene 2 | 1 3 0

							Cer	tificate o	f Death	,	Reg. No.		. • •
	Dharata		1. Decedent's Neme (First, Middle	, Last)						2. Dete of De Month	eath Day	Yeer	3. Time of Death
	Physic /Medi		Carolyn	Sue		Tayma	an			May 2		1991	1:04 PM
	Exami		4e. Facility Neme (If not institution 41328 Delabrook		imber)				4b. City, Town, or I Mechanic			y of Death Mary 's	
Ų.	Funeral Director		5. Social Security Number 216-40-7774	6. Sex 1 □ M 2√2 F	7. Age (In 59	yrs. last bin	thdey) Yrs.	If Under 1 Yee Months Dey		(Month, D	rth ey, Yeer) 9, 1938	9. Birthpla Country Washi	ice (Stete or Foreign y) ngton, D.
	pue **		Usuel Residence of Decedent  10e. Stete 10b. County		10c	City, Town	n or Loc	ation				100	d. Inside City Limits
	he Mary 28a-f sho outfied a	Director	Maryland St. M	ary's		Mecha	nics	sville		1			1 ☐ Yes Ž☐ No
	ath with t	rai Dir	10e. Street end Number 41328 Delabrook	Road					)659		10g. Citizen of U.S.		y?
020	s 1 and 2 should be filed within 72 hours efter death with the Maryland Health and Mentel Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Medical Exerciner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	12. Wes Dec Armed Fo ed 1 ☐ Yes If Yes, Gi Yeer or D	orces? 2 \ No ive	in U,S.		/es Decedent of Yes, specify Cu ☐ Yes 2 1 No	Hispanic Origin? (Siban, Mexican, Puert Specify:	pecify Yes or No Pican, etc.)	0- 14. Ra Ble Specii	ce - Americar ck, White, et y: Whi	c.
5-0	72 hc	eted	15. Decedent (Specify only highes	's Education		16a.	Decede	ent's Usual Occ	upation e during most of wor	kina	16b. Kind of B	usiness/Indu	istry
21215-0020	2 should be filed within and Mentel Hygiene. Is marked other than "reumetic event, the Med	Completed	Elementery/Secondary (0-12) 12th Grade	College (	1-4or 5+)			o not use retii ender	e during most of wor				
pue	be fill d oth even	Be	17. Fether's Name (First, Middle, William	Lawren		Chin	~		18. Mother's Nen	ne (First, Middle	, Maiden Sumei		-2
Maryland	hould d Mer marks matic	2	19a. Informent's Neme/Reletions		ice	Ship		Address (Chr.	Rose		0% - T	For	
	of Health and Itam 27 is in other traus		John Lawrence J			6	05 V	Vilson I	ane, Wald	lorf, M	20602		•
Baltimore,	00		20e. Method of Disposition 1 XBurial 2 ☐ Cremetion		State	cemeter	y, <i>cr</i> em	ition (Neme of etory or other p		Dete	20c. Location		
Itin	pemit. Peg Depertment Important: I any Injury o		4 ☐ Donation 5 ☐ Other (S)  21. Signeture of Funeral Service I		M	D Vet		ns Cemet		/2/97	Chelte	nham,	Maryland
Ba	Depermination of the series of		Muchan	04/2	-	-	Má	attingle	ey-Gardine				
P			23a. Pert1. Enter the disease, or shock, or heart feilure. List	complications that	caused the c	leath. Do n	P. not ente	O. Box or the mode of dy	270 Leor	or respiretory	n, Maryl errest,		20650 Approximete ntervel Between
5	Physician		orious, or rious tonuro. Elat									0	Onset end Deeth
1	/Medical Examiner		Immediate Ceuse (Finel disease or condition resulting in deeth)	e. Co	rono	red	A8	tery	Diseas	e			10 yes.
		e		ī	Due 1	o (or es e d	consequ	uence of):	failing	0.74			6
	uted d ansit	Examiner	Sequentially list conditions	b	T t g	o (or es e o	VTV Oneenu	ience off.	10011	XIE.			2 24.
x 68760,	ertificete be executed ing physician and e es the buriel-transit	Physician/Medical Ex	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underfying Ceuse (Diseese or Injury the Initiated events resulting In deeth) Last	c	Non		010	struct!	ne Palm	warz	Disea	se !	5 ym.
Box	death cert	sician/	Part II. Other significant conditio		eath but not	resulting In	the un	derlying cause ç	given in Pert I.	23b. Dld	tobecco uee co	entribute to t	the cause of death?
s, P.O.	es thet the de Igned by the a be deteched t	by Phy	Smoker.							1□	Yes 2□No	3 ⊡ Probe	ably 4 ☐ Unknown
of Vital Records,	ew requires been so should	Completed t									s an eutopsy ormed?	com	e autopsy findings leble prior to pletion of cause eath?
<u>ه</u>		Соп								10	Yes 2 No	10	Yes 2 No
Vita	ysiclan: The serificate director, per	Be	25. Wes case referred to medical examiner?	Hospitel:					26. Plece of Dea	th (Check only	one)		
o	Phys this ral di	: To	1 Yes 2 1 No  27. Menner of Deeth	28e. Dete		2 ER/Out	<u> </u>	3LI DOA			how injury occur		
0	After fune	tion	1 Naturel 5 Pending	(Mon	th, Day Yea		njury	28c. Inj W M 1[	ork? □ Yes 2 □ No	200. Describe	now injury occu	100	
Division	F # = C	Certification:	3 Suicide 6 Could r 4 Homicide determi	ned 266. Piece	of Injury - Aing, etc. (Sp	At home, far ecify)	rm, stre	et, fectory, office	•		(Street end Num wn, Stete)	ber or Rural I	Route Number,
	To the Hospital or Attent within 24 hours effer deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 ☐ Certifying (Check only one)	xaminer: On the b	best of my asis of exam ner steted.	knowledge,	, deeth Vor Inve	occurred et the estigation, in my	time, dete end plece opinion, death occu	, and due to the rred et the time,	ceuse(s) end m , dete end plece,	enner es stet end due to t	ted. he cause(s)
	ro the	Me	29b. Signeture end title of cartifier	One interior					nse number		29d. Date signe	d (Month, De	ey, Year)
			N-K. J.	yaraw	an	an		D	313 41	r	Mary	28,	1997
	4)		30. Neme end eddress of person v	who completed caus	se of death (	Item 23e) (			n Rd., Med	chanics	ville, M	ID 206	559
Ì	Sta Registr		31. Date filed (Month, Dey, Yeer)										

THE PERSON NAMED IN e rice rank w

by

Completed

Be

permit. Peges 1 and 2 should be filed within 72 hours effer c Depertment of Health and Mental Hygiena. Important: If Item 27 Is marked other than "natural", or iter any injury or other traumatic event, the Medical Exami

**Physician** 

/Medical

Examiner

physician end the buriel-trensit

ettending pl

signed by the et d be detached fo

P.O. Box 68760,

Division of Vital Records,

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific

To the within 2

funarai

filled in by tha

Examiner

Physician/Medical

þ

Completed

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2

Certification:

Medical

9

Baltimore, Maryland 21215-0020

### Please Type or Print in Black Indelible Ink. Assure Ali Copies Are-Legible,

State of Maryland / Department of Health and Mental Hygiene

ROBERT L. TURNER Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Daath Day Month **Physician** ROBERT L. TURNER 23, JUNE /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner AIRPORT-BLUE LOT ROW FF ODENTON ANNE ARUNDEL If Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Hours 1√2 M 2□ F Yrs 222-18-0808 Director JAN.27,1930 Usual Residence of Dacedant death with the Maryland 10b. County show 10a State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at Director DELAWARE SUSSEX MILLSBORO 10e. Straat and Number 10g. Citizan of What Country? 10f. Zip Coda 19966 USA (MARINER'S COVE) 33 KNOLLWAY Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☑Yas 2 ☐ No If Yas, Giva Year or Dates: Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc.

3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grade complated) Elementary/Secondery (0-12) Coilege (1-4or 5+)

1 ☐ Yas 2 ☐ No Specify: 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired)

16h Kind of Business/Industry AIR CONDITION & AIR CONDITION & HEATING ENGINEER HEATING

WHITE

Yaer

1997

3. Tima of Daath

Birthplaca (State or Foraign Country)

PORTLAND, OREGON

10d. Inside City Limits

1 ☐ Yas 2 No

2015PM

12 17. Fether's Nama (First, Middle, Last)

1 □ Navar Married 2 N Married

18. Mothar's Nama (First, Middla, Maidan Sumama) SARAH ARMSTRONG

CHARLES L. TURNER 19a. Informant's Name/Ralationship (Typa, Print)

19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 33 KNOLLWAY (MARINER'S COVE), MILLSBORO, DE 19966

CATHERINE TURNER, WIFE 20a. Method of Disposition 1 Burial 2 Commation 3 Ramoval from State 4 Donetic 5 Dthar (Specify)

20b. Place of Disposition (Nama of cematery, cramatory or other place) HENLOPEN MEMORIAL PARK 6/27/97

20c. Location - City or Town, Stata MILTON, DELAWARE

LONG NECK RD., MILLSBORO, DELAWARE 19966 or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory errest, but only one cause on each line.

22. Name end Addrass of Facility MELSON FUNERAL SERVICES, LTD.

Immadiata Causa (Final disaasa or condition resulting in daath)

Atherosclerary lardibruscular disege Dua to (or as e consaquanca of)

Onsat and Deeth

Sequantially list conditions, if any, laading to immediata cause. Enter Undarlying Ceusa (Disaasa or injury that initiated avants rasulting in daath) Last

Due to (or as a consequence of):

Dua to (or as a consequence of)

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown

24a. Wes an autopsy performed?

Approximate Interval Batween

Purhad

24b. Wara autopsy findings eveileble prior to complation of cause of daath?

1 Yes 2 □ No

26. Place of Death (Check only one)

1 Ves 2□ No

25.	Was casa examinar?	referred to medical	
	1 X Yas	2□ No	
27.	Menner of	Daath	

5 Panding Investigation 6 Could not be determined 28a. Dete of Injury (Month, Day Year)

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

Othar:  $_{4}\square$  Nursing Homa  $_{5}\square$  Rasidance  $_{6}$  Mothar (Specify) AT SCENE 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier

1 Natural

2 Accident

3 Suicida

4 Homicide

1 Certifying Phyalcian: To tha best of my knowledga, daath occurred at the time, date end place, end due to the cause(s) end menner es statad.

The Madical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, data and place, and due to the cause(s)

29b. Signatura and title of certifier

29c. Licensa number

O.C.M.E.

29d. Date signed (Month, Day, Yaar)

JUNE 24, 1997

30. Nama and eddrass of person who complated cause of death (Item 23a) (Type, Print)

Hospital:

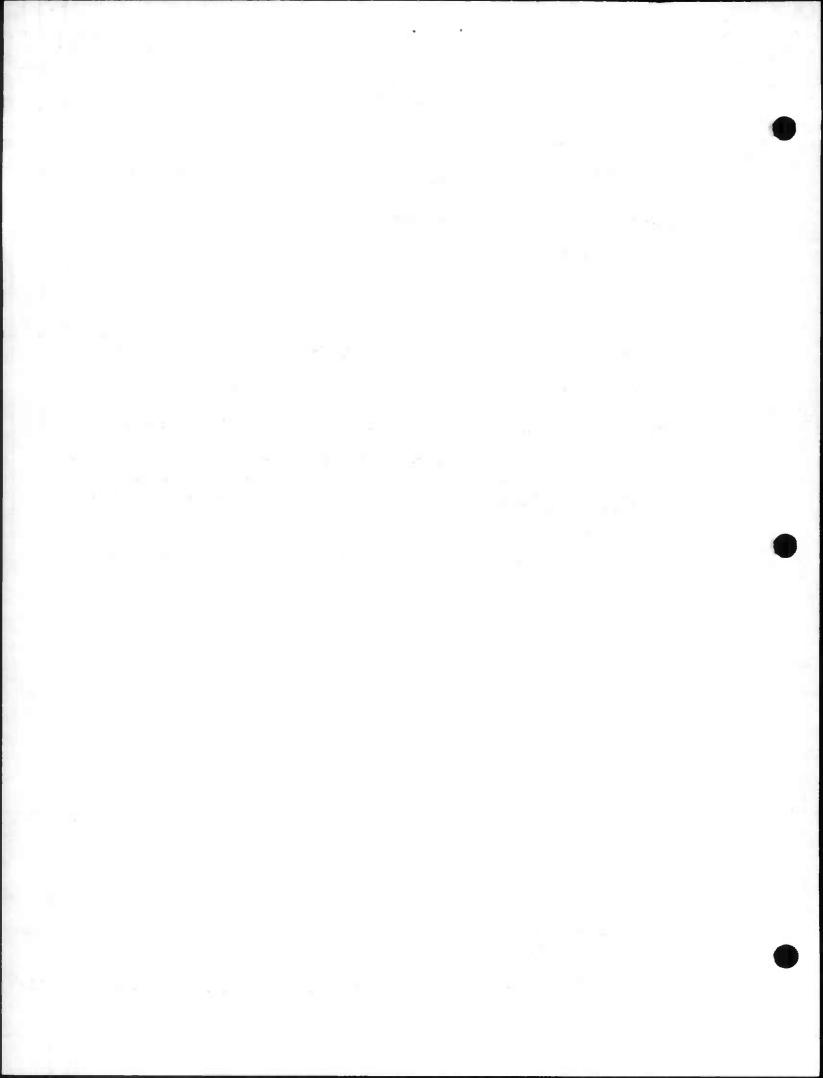
rowler 100id

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Yaar) **JUN 26** 

32. Registrar's Signatura La Davelson Revdell



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State of Maryland / Department of Health and Mental Hygiene

 0			_	-
1		1	2	9
6	1	1	3	6

IRENE TURPIN

**Physician** 

Certificate of Death

2. Date of Death

JUNE

CITY

8. Data of Birth (Month, Day, Year)

3-2,1927

3. Time of Death 1997 4:25P.M.

/Medical Examiner

4a. Fecility Nama (If not institution, give street and number) 32403 OVERHOLT ROAD

Virginia

6 Sax

1□ M 2 F

1. Decedant's Nama (First, Middle, Last,

4b. City. Town, or Location of Daath

POCOMOKE

If Undar 24 Hrs.

Hours

28 4c. County of Death

Md.

**Funeral** Director

Show

7 is marked other than "natural", or frems 23s or 28s-f shov traumstic event, the Medical Examiner must be multified at

permit. Pages 1 end 2 should be filed within 7. Department of Heelth end Mental Hygiena. Important: If Item 27 is marked other than "nu any injury or other traumatic event, The Media 2006.

Physician

/Medical Examiner

signed by the attending physician end d be detached for use as the burial-transit

has

funeral

Aftert

death.

or Attand after death Director: /

24 hours a Funeral D

To the Hosp within 24 hos To the Fune completaly fi

tha daath certificate be axecuted

Box 68760.

Division of Vital Records, P.O.

Examiner

Physician/Medical

þ

Completed

Certification:

daath with the Maryland

filed within 72 hours aftar

altimore, Maryland 21215-0020

Director

Funeral

þ

214-32-6370 Usual Rasidance of Dacedant 10a. Stata 10b. County Md. Somerset 10e. Street and Number

Irene

5. Social Sacurity Number

10c. City. Town or Location Pacamake

City 10f. Zip Code

21851

If Under 1 Yaar

Days

Months

10d. Insida City Limits 1 Yas 2 No

Birthplace (State or Foreign Country)

10g. Citizan of What Country?

U.S.A.

SOMERSET

32738 Rehobeth 11. Marital Status

1 Navar Married 2 Married 3 ☐Widowed 4 ☐ Divorced

Rd. 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐No If Yas, Giva Year or Dates:

Turpin

7. Age (In yrs. last birthday)

 Was Decedant of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1 ☐ Yas 2 TNo Specify:

14. Race - American Indian. Black, Whita, atc.

15. Dacedent's Education (Specify only highest grade completed)

Turner

16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Black 16b. Kind of Business/Industry

Elementery/Secondary (0-12) 7th Grade

College (1-4or 5+)

Nursery La bera

Bountful Ridge

20c. Location - City or Town, Stata

17. Fathar's Nama (First, Middle, Last)

Turner Louvie King

18. Mothar's Nama (First, Middle, Maiden Surname)

James 19a. Informant's Name/Ralationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32738 Rehobeth Rd. Pocomoke Md. 21851

Daughter Helen A. Hitch 20a, Method of Disposition 1 Burial 2 Cremation 3 Ramoval from State

20b. Place of Disposition (Name of cemetery, crematory or other place) M.E. Cemtery

7-7-97 Pocomoke City, Md.

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funarai Sarvica Licensaa

3812 Davis Rd.New

moda of dying, such es cardiac or respiratory arrest,

22. Nama end Addrass of Fecility Savage Funeral

23a. Part1. Entar tha disaasa, or complications that a shock, or haart failura. List only one causa on a

Church, Mn. 23415 Approximata Interval Between Onset and Death

Immediate Causa (Final diseasa or condition resulting in daath)

Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Ceusa (Disaasa or injury that initiated events resulting in death) Last

Dua to (or es e consequance of)

Dua to (or as a consequence of):

Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown

24a. Was an autopsy performad?

24b. Wera autopsy findings available prior to complation of ceusa of daath?

26. Placa of Daath (Check only one)

25. Was cesa raferrad to medical examinar? Hospital: Mas 2 No 27. Manner of Death

5 Panding invastigation

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of

reported 6/2/197 1 Yas 2 No

Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify, 28d. Dascribe how injury occurred

byect

28a. Place of Injury - At homa, farm, straet, factory, office 123 building, atc. (Specify) 6 Could not ba 4 Homicida Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and due to the causa(s) and mennar as stated.

Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29a. Certifiar

61-8197

29b. Signatura and title of certifiar

1 Natural

2 Accident

3 ☐ Suicide

(Check only one)

29c. Licensa number

29d. Date signad (Month, Day, Year)

Co-

O.C.M.E.

JUNE 29, 1997

30. Nama and addrass of person who complated course of death (Itam 23a) (Type, Print)

HEODORE MIKIL

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Data filad (Month, Day, Year) JUL 01 1997

2. Registrar's Signature Vin Stwelson Randall

a your DECEMBER OF THE PROPERTY OF TH 

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21133

			Certificate of Death	Reg. No.
Discolati		1. Decedent's Name (First, Middle, Last)		Date of Deeth     3. Time of De
Physici /Medic		William Edward Thomas	_	June 24. 1997
Examir		4e. Fecility Neme (If not institution, give street end number)	4b. City, Town, or Loc	ation of Death 4c. County of Deeth
		Charlotte Hall Veterans Hom	e Charlotte	Hall St. Mary's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest bi	irthday) If Under 1 Year If Under 24 Hrs.  Months Deys Hours Min.	8. Date of Birth (Month, Dey, Yeer) 9. Birthplace (State or Fo
Director		078 16 7451 X X 2□F 77 Usuel Residence of Decedent	Yrs. World's Deys Hours Will.	une 22, 1920 Pa.
filed within 72 hours after death with the Meryland Hygiene. ther than "neturel", or terms 23a or 28a-f show ent, the Medical Evaniner must be notified at		10e. State 10b. County 10c. City, Tov	vn or Location	10d. Inside City L
Me	to	Maryland Prince George's Tem	nle Hills	1 ☐ Yes 2[
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	i e	10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
38 c	0	3705 Spring Terrace	20748	United States
De filed within 72 hours after death with the Marylan Ital Hygiene. Ital Hygiene. Adother than "neturel", or items 23a or 28a-f show event, the Mary cal Examiner must be notified at	Funeral Director	11. Maritel Stetus 12. Was Decedent Ever in U,S.	13. Was Decedent of Hispenic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F	
or Ite		Armed Forces?  X Y Yes 2 □ No WW  Tyes, Give		
urs urs	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 21X No Specify:	Specify: White
etur Gal	Completed	15. Decedent's Education 16e	. Decedent's Usuel Occupetion	16b. Kind of Business/Industry
nn '	pie	(Specify only highest grede completed)  Elementery/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of workin life. DO NOT use retired)	g
Hygiene.  Sther than 'ent, the Me	000		ield Maintance	Cival Service
should be filled and Mental Hygi marked other imatic event, t	Be	17. Father's Neme (First, Middle, Last)		(First, Middle, Maiden Surneme)
ked ice	To B	William Thomas	Alice	Plank
th end Mental by 7 is marked of traumatic eve			b. Mailing Address (Street end Number or Rural	
ta ta				, Temple Hills, MD 207
f Health tem 27 i				Date 9 9 7 20c. Location - City or Town, Stete
int of		121201101 2 LICIONIANON 3 LINGUIGANITONI SIGLE		Choltonham MD
rtan		4 □ Donation 5 □ Other (Specify) Mary1  21. Signature of Funeral Septical	and Veterans Cemet	era
Department of Heal Important: If Item 2 any Injury or other 200ce.		21. Signature of Furieries September 1		Funeral Home, Inc 6633 erry Rd, Clinton, Md 20
xaminer	Examiner	disease or condition resulting in deeth)  Due to (or es e  Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse, Disease of Injury  c.	consequence of):	
etir cermicate be executed ether and ether and for use es the buriel-trensit	Medical		consequence of):	
ate has been signed by the etter	Physician/	Part II. Other eignificent conditions contributing to death but not resulting I	n the underlying ceuse given in Part I.	23b. Did tobacco use coptibute to the cause of de
igned by the e	h.			1 Yes 2 No 3 Probably 4 Unit
peug e	by	1963 heimen	Discare	
been sig				24a. Wes en eutopsy performed? 24b. Were eutopsy findii eveilable prior to
s be	Completed			performed? eveilable prior to completion of caus of deeth?
ate has	E O			1 Yes 2 No 1 Yes 2 No
	Be C	25. Wes case referred to medical	26. Place of Death	
	To B	examiner? 1 ☐ Yes 2 ☐ DK  Hospital: 1 ☐ Inpatient 2 ☐ ER/Or	Other:	e 5 Residence 6 Other (Specify)
ar this eral d		27. Menper of Death 28e. Dete of Injury 28b.	Time of 28c. Injury et 21	3d. Describe how injury occurred
or death.	atio	1  Naturel 5  Pending (Month, Dey Year) 2  Accident investigation	Injury Work?  M 1 Yes 2 No	
s efter death. If Director: Af	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, for	arm, street, fectory, office	Bf. Location (Street end Number or Rural Route Number,
Dire	ert	4 ☐ Homicide determined building, etc. (Specify)		City or Town, State)
4 hour Funera tely fills	edical C	29e. Certifier (Check only)  1 ☐ CertifyIng Phyelclan: To the best of my knowledge 2 ☐ Medicat Examiner: On the basis of examinetion en	e, death occurred et the time, date end place, end/or investigation, in my opinion, death occurred	nd due to the ceuse(s) and menner es steted.  d et the time, date end plece, end due to the cause(s)
within 2 To the complet	Med	end manner stated.		
1 × 0 0		29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
			752665	- 6/24/97-
		30. Neme end eddress of person who completed seuse of deeth (Item 23e)		
		KHADAR BAIG	18N 310 Hwy, Box	190, LaPlata, Md 2064
		31. Date filed (Month, Day, Year)  32. Registrer's Signature	0	
		KHADAR BALG	18N 310 Hwy, Box	190, LaPlata, Md 2064

. . .



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_				State o	f Maryla			of Health a of Death	and M		giene /	4	1134
	Physic /Medi		1. Decedent's Neme (First, Mid Aqui	<sup>(dle, Last)</sup> Lla Toliv	er					2. Date of Dee Month	Dey	Yeer	3. Time of Death
	Exami		4e. Fecility Neme (If not institute Mariner Hea			rn Md			ntor		/97 4c. County Prin		8:3 <del>0pm</del> eorges
	Funeral Director		5. Social Security Number 578-50-8997  Usuel Residence of Decedent	6. Sex 1 □ M 2√2 F	7. Age (In yrs 91	: lest birthday) _ Yrs.	If Under 1 Y	eys Hours	24 Hrs. Min.	8. Date of Birth (Month, Dev 4/23/		9. Birthpl Count	ece (State or Foreign (ry) Oline Co
	th the Maryland or 28a-f ehow	Director	10a. State 10b. Coun			ity, Town or Loo Washin					10g. Citizen of		Od. Inside City Limits  XOXYes 2 □ No
020	De filed within 72 hours after death with the Maryland ntel Hygiene.  do other than "neturel", or Items 23e or 28e-f ehow event, "in Med cal Exerriner must be incitled at	by Funeral	2351 Pit  11. Marital Status  1 Never Married 2 Ma  32 Widowed 4 Divorce	M Man Oir	ces? 2 No			0 2 0 of Hispenic Orig Cuban, Mexican,	gin? (Spec , Puerto R	cify Yes or No- lican, etc.)	Specify	ce - America ck, White, e	etc.
d 21215-0020	should be filed within 72 ho d Mentel Hygiene. marked other than "netur imatic event, the Medical	e Completed	15. Decede (Specify only high Elementary/Secondery (0-12) 1 2		-4or 5+)	(Give k	ent's Usual O tind of work d to NOT use n	lone during most etired) TESS			16b. Kind of B  Cloth  Maiden Sumen	ing	ck ustry
, Maryland	2 should and Mei is marke eumatic	To Be		H Brown				treet end Number	Bet r or Rure/	ty Wi Route Numbe	lliams r, City or Town,	Stete, Zip	Code) Va 22546
Baltimore,	permit. Pages 1 and Department of Health Important: If them 27 any injury or other tr 90cs.		20a. Method of Disposition  1 Burial 2 Cremation 4 Donaldon 5 Dether ( 21. Signature of Fungual Service)	Specify)	ituse.	cemetery, crem	atory or other	07	6/	Date	20c. Location -	City or Tov	vn, Stete
Total Control	Physician /Medical Examiner	ılner	23a Part Enter the Assass, a shock of heart failure. List immediate Cause (Final disease or condition resulting in deeth)	. M	141	th Do not ente	STE		Fr cerdiac or	ederic respiretory eri		g Va	Approximate Intervel Between Onset end Deeth
Box 68760,	death certificete be executed e ettending physician end of for use as the bunal-transit	n/Medical Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest	c		or es e consequ							
P.O.	v requires that the deat been signed by the ett should be detached for	ted by Physician/Me	Part II. Other algnificent conditions of the con	ic Re.							es 2 No	3 ☐ Prob	the cause of death?  ably 4 Durknown  re eutopsy findings leble prior to
al Records,	The law ete has b page 2 s	Completed								1 🗆 Y		con of d	pletion of cause eeth? Yes 2□ No
Division of Vital	or Attending Physicien: The efter death.  Director: After this certificete in by the funeral director, pag	Certification: To Be	3 Suicide 6 Could	Hospital: 1 In In In In In In In In In In In In In	Injury , Day Year)	28b. Time of Injury	28c.	Other: 4 Nurselnjury et Work?	sing Home	3d. Describe ho	ence 6 Oth	red	
Δ	To the Hospital or Attending within 24 hours efter death.  To the Funeral Director: After completely filled in by the fune.	edical	(Check only 2   Medical one)	ng Physician: To the b Examiner: On the bas and menne	est of my kno	wiedge, deeth	occurred et th	e time, dete end	plece, en	d due to the c	ause(s) end me	enner es ste end due to	eted. the ceuse(s)
)	To	×	29b. Signature end title of certific	July,	of death Mer	n 23e) (Tvna P	20	+543			9d. Date signed	97	ley, Yeer)
	Sta Registr		Suite 301 31. Date filed (Month, Day, Year	) 32 Re	gistrer's Signa	TAL P	7	Brin	ce f	Frede	rick	WD	20678

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Death Day Arlene M. Twomey 11:30 p.m. June 16, 1997 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 2701 Felter Lane Prince George's Months Days Hours Min. 8. Date of Birth (Month, Pay, Year) 13 9. Birthplace (State or Foreign Country)
Maine 7. Age (In yrs. last birthday) 1□ M 2XF 84 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 2701 Felter Lane 20715 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Married 2XXMarried 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16e. Decedent's Usual Occupation (Give kind of work done duning most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Frank Leon McKenney Edith Jewel 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Raymond E. Twomey Same as # 10. 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 12 Burial 2 Cremetion 3 Removel trom State 4 Donetion 5 Other (Specify) Laurel Hills Cemetery 6/20/1997 Saco, Maine 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie, MD 20715 23. Part. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. End Stage COPD

Due to (or es e consequence of): 10 years 2 years Due to (or es e consequence ot): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 1□ Yes 2□No 25. Was case reterred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Presidence 8 Other (Specify) 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Yes 2 No

Division of Vital Records. P.O. Box 68760.

Examiner **buriel-trensit** physician s the buriel Physician/Medical After this certificate

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examinar must be notified at

permit. Peges 1 end 2 should be filed within 72 hours efter death with I Deportment of Heelth and Mentel Hygiene. Important: If Item 27 Ia marked other than "natural", or Itema 23a or is any injury or other traumatic event, the Modical Experience meast have

**Physician** 

/Medical

Baltimore, Maryland 21215-0020

the Marylend

5. Social Security Number

005-01-8179

10e. Street end Number

20a. Method of Disposition

tmmediete Ceuse (Finel diseese or condition resulting in deeth)

Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Lest

1 Yes 2 € No

27. Menner of Deeth

1 Natural

2 Accident

4 ☐ Homicide

3 Sulcide

29a. Certifier

Musk

10a State

Director

Funeral

2

Completed

Be

2

Examiner

by

Completed

Be

To

Hospital or Attending Physician:
 124 hours efter death.
 Funeral Director: After this certificalletely filled in by the funeral director.

Certification: mpletely To the I

31. Dete tiled (Month, Day, Year) Registrar

29b. Signeture end title of certifier Rait Falm M.D.

29c. License number D43446 29d. Date signed (Month, Day, Year) 6.17.97

28f. Location (Street end Number or Rural Route Number, City or Town, State)

30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

RUINTAN FARAHI FAR M.D. 4000 Mitchelleville read 3216 Bowis MD 20716

1 Evertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

JUN 24 1997

6 Could not be determined

32 Registrar's Signeture

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

No. - The state of the state of

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State of Maryland /	Department of H	lealth and Mental	Hygiene9 /	21	3	6

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month Physician Robert Ε. Thomas June 20, 1997 11:15 A.M /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 15306 Pine Tree Way Bowie Prince George's If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In vrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) **Funeral** Months ★ M 2 □ F Devs Director 212 07 4734 June 16, 1912 Maryland Usuel Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examinar mast be notified at ¥Yes 2□No Director Maryland Prince George's Bowie 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 15306 Pine Tree Way 20721 United States Funeral or items 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. XXYes 2 □ No if Yes. Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2√√No Specify: à Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 43-44 Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) permit, Pages 1 end 2 should be filed wi Department of Health and Mental Hygien, Important: If Item 27 Is marked other the any Injury or other trauments Sales Automotive 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be William E. Thomas Virginia E. Geist 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Jerome E. Hoobler Nephew P.O. Box 30405 Bethesda Maryland 20804 20b. Place of Disposition (Name of cemetery, cremetory or other place) June 23, 1997 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ♣ Fremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory Alexandria Virginia dure of Funeral Service Licens 22. Name end Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715 a. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, List can one ceuse on each line. Approximate intervel Between Onset end Death **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting in death) Examiner Examiner The law requires thet the death certificete be axecuted burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest and Due to (or es e consequence of): P.O. Box 68760, attanding physiclan Physician/Medical the Due to (or es a consequence of) usa as Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? signed by t PNEUMONI 1 Yes 2 No 3 Probably 4 Unknown Records, ð 24b. Were eutopsy findings evailable prior to completion of cause of death? Completed 24a. Was en eutopsy performed? certificate 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 D N Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannel of Deeth 28e. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 Natural 5 Pending investigation aftar daath. I Director: Aft d in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours aftar within 24 hours a To the Funeral D llad Medicai 29a, Certifier Certifying Physicien: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner es steted. Certifying Physicien: 10 the basis of a Medicat Examiner: On the basis of a manny state. camination end/or Investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) 29b. Signatu 29d. Date signed (Month, Dey, Yeer) Day, Year) State JUN 24 1997 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

					Ce	rtificate	of	Death		B	leg. No.			
Di .		1. Decedent's Name (First, Middle, La	ast)							2. Dete of Dee	th		3. Time of D	eath
Physici /Medi		DOROTHY L		ТНОМ	PSON					JUNE JUNE	13,	1997	5:00 A	M
Examir		4e. Fecility Name (If not institution, given 14904 4th Street						tb. City, Tov Laure 1		ocation of Death	4c. Cou	nty of Deel	orges	
Funeral Director		213-18-6160	Sex 1□ M 2∏ F	7. Age (In yrs. 80		If Under 1 Months E	Year	If Under 2 Hours	24 Hrs. Min.	8. Dete of Birth (Month, Day May 19,		9. Birt	hplace (Stete or I	Foreig
f show	or	Usual Residence of Decedent  10e. Stete 10b. County MD . PG			y, Town or Lo	cation							10d. Inside City	
a or 26e	I Direct	10e. Street end Number 14904 4th Street,	#204			10f. Zip Co		20707		1	0g. Citizen o	of Whet Co	untry?	
itel Hygiens are dead war in the way in the life way in the life war in the li	by Funeral Director	11. Maritel Status  1 □ Never Married 2 □ Married  3 ₺ Widowed 4 □ Divorced		2 ₹ No		Was Deceden f Yes, specify 1 ☐ Yes 2 ∏	Cube	lispanic Orig en, Mexican, Specify:	gin? (Sp , Puerto	ecity Yes or No- Rican, etc.)	8	Raca - Ame Bleck, White cify: B1a	•	
ane. than "natur	Completed by	15. Decadent's E (Specify only highest gri Elementary/Secondary (0-12)	ducation ede completed) College (1	-4or 5+)	(Give	dent's Usuel C kind of work of DO NOT use i	done retire	etion during most i)	of work	ing	16b. Kind of		Industry	oui
entel Hygie ked other ic event, tr	To Be Co	17. Fether's Neme (First, Middle, Last Henry Thompson	)		110000					e (First, Middle, I				
ofth end M 27 is mari		19a. Informent's Neme/Relationship (								e/Route Number		_	Zip Code)	
Deportment of Heelth and Maniel Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the M. ODCE.		20e. Method of Disposition  120 Burial 2 Cremetion 3 C  4 Donation 5 Other (Specif	Removal from S	State	Place of Dispo emetery, crer	sition (Neme netory or othe nal Men	of r plac	:e)			20c. Locatio	n - City or	Town, State	
Depentral Imports any Injuing		21. Signeture of Funeral Service Licer	nsee L C	1.		Name end A	ddre	s of Facility	nera	1 Home,	Inc.			
hysician 'Medical xaminer	er	23a Part 1. Enter the disease, or com- phock, or heart failure. List only Immediate Ceuse (Final disease or condition resulting in death)		olow		WCE						1	Approximete Intervel Betwee Onset end De	ath 1
y the attending physician end sched for use es the bunel-transit	/Medical Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest	b	_	r es e conseq	,								
led by the attendi	Physician/	Pert II. Other elgnificent conditions of		eth but not resu	ulting In the ur	nderlying caus	e giv	en in Pert I.			/		to the cause of	
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hes t	Completed									perform	med?		eveileble prior to completion of cau of deeth?	SO /
is certific director,	To Be (	25. Wes case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Ir	patient 2	£R/Outpetien	t 3 DOA	Oth	or.		me 5 Reside		Other (Spec	oify)	
eath. or: After the funer	Certification:	27. Menney of Deeth  1 Matural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Placa	of Injury - At ho	28b. Time of Injury	-м		yet ⟨? Yes 2□N	lo	28d. Describe ho			rel Route Numbe	v.
within 24 hours effer d To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Ph	buildin	g, etc. (Specify	vledge, deeth	occurred et th	ne tim	ne, date end	placa	City or Town	n, State)	menner es	eteted	
within 24 hours e To the Funeral C completely filled	Medical	(Check only 2 Medical Examone)  29b. Signature and title of certification of the control of the certification of t	s mann	er steted.		29c. Li	cense	number		25	9d. Date,sigi	ned (Month	to the cause(s)	
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State of Maryland / Department of Health and Mental Hygiene 2 | 1 3 8

SANDRA A. TURNER

	Items	23a	part I,27 per MEO G-	749 7/14/97 dh	Cer	tificate o	f Death	F	Reg. No.		
	Physic	an	1. Decedent's Name (First, Middle, La	•				2. Date of Dee	oth Day	Yaar	3. Time of Death
	Physic /Medi		Saundra	A. Turner			,			997	0418AM
	Exami		4a. Facility Name (If not institution, given	The second second			4b. City, Town, or	Location of Death	4c. County	y of Death	
			2210 BRIGHTSEA			Rite de la Meri	LANDOV	-			GEORGES
	Funeral Director		214-58-2091	Sex 7. Age (In yrs. 4.4	last birthday) Yrs.	If Under 1 Year Months Day		8. Data of Birtl (Month, Da) 03-0	2 - 53	9. Birthp Coun Wash	laca (State or Foreig itry) ington DC
	Marylend f show	tor	Usual Residence of Decedent  10a. State 10b. County Maryland Prince	George's	y, Town or Loc		ndover			1	0d. Inside City Limite
	3a or 28a	al Director	10e. Street and Number 2210 Brightsea	t Road #301		10f. Zip Coda	20785		10g. Citizen of	What Coun	try?
020	permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show shipiup or other traumatic event, the Medical Examinal must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Noivorced	12. Was Decedent Evar in U, Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of Yes, specify Cu	f Hispanic Origin? (S uban, Mexican, Puerl o <i>Specify:</i>	Specify Yas or No- to Rican, etc.)	14. Ras Bla Specil	ce - Americ ck, White, by: Bla	
5-0	72 h	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16e. Deced	ent's Usuel Occ	upation le during most of wo red)	rking	16b. Kind of B	usiness/Inc	Justry
121	vithin han "	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D				0		
2	lled v lygie her ti nt, th	8	17. Father's Name (First, Middle, Last	1+		Secre		ma (First, Middle,		vernm	ent
and	ad be for to be	Be	John W. Turne					rnette E		110)	
Z	shouk ad Me mark matic	2	19a. Informant's Name/Relationship		19h Mailin	n Address /Stre	et and Number or Ru			State Zin	Code)
e, Ma	1 end 2 s Health er em 27 is ther trau		Burnette Turner, 20a. Method of Disposition	Mother	6884	Riverda	le Road #	443, Lar	nham, M	aryla	nd 20706
Baltimore, Maryland 21215-0020	tment of I tant: if ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State Ha	emetery, crem rmony	Memoria	1 Park	7/2/97			Maryland
Bal	Depermition Depermine Important Impo		21. Signature of Funeral Service Licer	Perconti	22.		<sub>lress of Facility</sub> enkins Fu andover R			Maryl	land 2078!
	Physician /Medical Examiner	niner	23a. Part1. Enter the disease, or comshock, or heart failure. List only  Immadiata Cause (Final disease or condition resulting in death)	a. ARTERIOSCLERO		IOVASCULA					Interval Between Onset and Death
Box 68760,	The law requires that the death certificete be executed at hes been signed by the ettending physician end page 2 should be detached for use es the buriet-trensit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last	C	r as a consequ						
Ď.	death e etter d for	Icla	Part II. Other significant conditions of	ontribution to death but not resu	ulting in the un	derlying cause	nivan in Part I	23h Did t	obacco usa co	ontributa to	the causa of death
, P.O	es that the death cer igned by the ettendir be detached for use	by Physician/			ating with the arr	deliying oddao	givan ii i aici.		res 2□ No	3 □ Prot	
Division of Vital Records,	e law requires hes been sig ge 2 should b	Completed b						24a. Was perfo	an eutopsy med?	co	ere autopsy findings ailable prior to mpletion of cause death?
<u>=</u>		00						1/21	'es 2□No	1'8	Yas 2 No
/ita	ician: Th certificate rector, per	Be	25. Was case referred to medical examiner?	11.50				eth (Check only o	ne)		
of	Physic this c	5	1 X Yes 2 No		ER/Outpatient	3LI DOA		loma 5 Resid			()
on	Jing F After funer	tion:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. in W	juryet /ork? □Yes 2□No	28d. Describe h	ow injury occu	rred	
Divisi	는 다음 다	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	e one Blace of Livery As he	ome, farm, stre	et, factory, offic	е	28f. Location (S City or Tow	Street and Num m, State)	ber or Rura	i Route Number,
	Hospital 24 hours Funeral letely filled	Medical C	29a. Certifier 1 ☐ Cartifying Pt (Check only one)	yalclan: To the best of my knowninar: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the estigation, in my	time, date and place opinion, death occu	and due to the curred at the time,	cause(s) end m date and placa,	anner es st	eted. the cause(s)
	within To the	Me	29b. Signature and title of cartifier	D' 0 -		29c. Lice	nse number		29d. Date signe	ed (Month,	Day, Year)
			I May te	The Strill		0.	C.M.E.		JUNE	25,	1997
			30. Name and address of person who	completed cause of death (Item		Print)					
			31. Date filed (Month, Day, Year)	S.100 Hoer		enn St	reet, B	altimor	e, Mai	rylan	d 21201
	Sta Registr		JUL 01 1997	Pogistrano Signa	uste						

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State of Maryland / Department of Health and Mental Hygiene

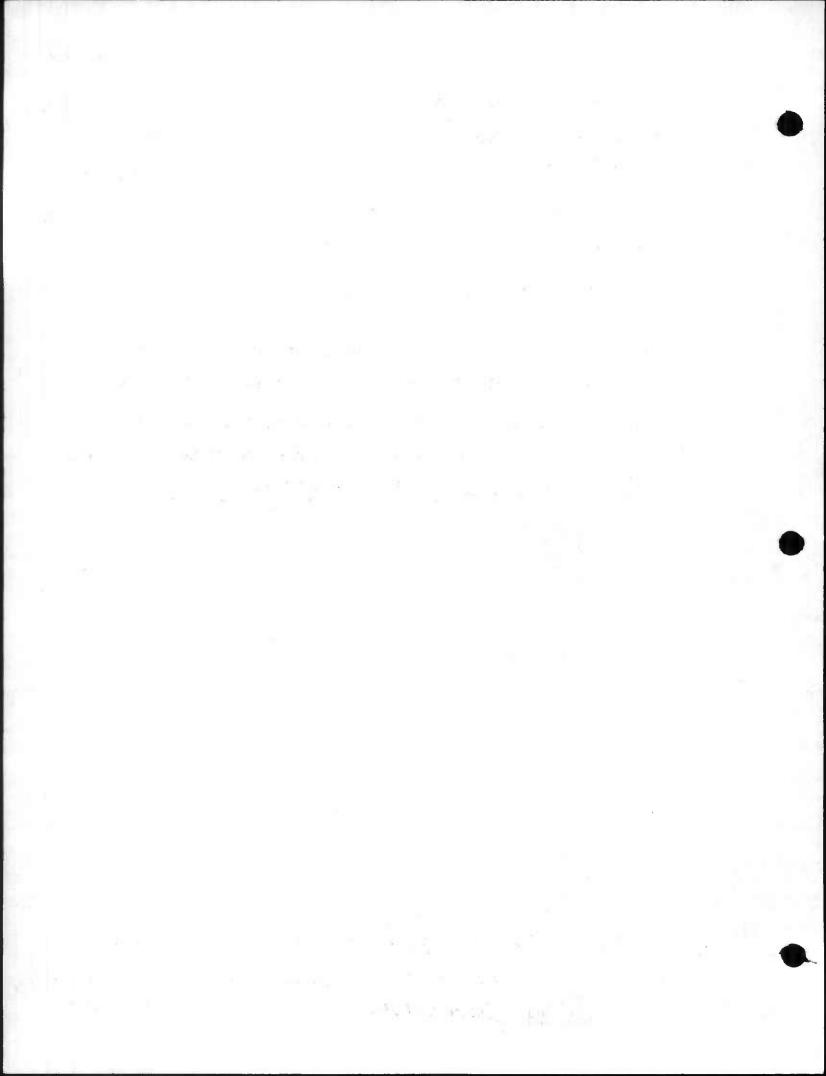
Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Death 3. Time of Death Month **Physician** Year JUNE 21, 1997 2045 /Medical 4a. Fecility Name (If not institution, give street end numbar) 4b. City. Town, or Location of Daeth 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number If Undar 1 Year | if Undar 24 Hrs. 9. Birthplace (State or Foreign Country) New Jersey 7. Age (In yrs. lest birthday) Funeral Months Deys Hours 1□ M 2/2√F Yrs. Director 140-14-7369 86 May 30, 1911 Usuel Residence of Decedent death with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "natural", or Items 23e or 28a-f show traumstic event, the Modical Examiner must be notified at 1 ☐ Yas 2 X No Director Maryland Calvert Port Republic 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U. S. A. 20676 1415 Walnut Road Funerai 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, permit. Peges 1 end 2 should be filed within 72 hours after c Department of Health end Mental Hygiene. Important: If Item 27 is marked other then "natural", or Item any Injury or other traumatic excess. Black, White, etc. 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: g Specify: 3∕ Widowed 4 Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Home Maker Own Hame 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Thomas Wilson Ida Dresbach 19a. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Marjorie Ryan/Daughter 5903 Sixty-First Avenue Riverdale, Maryland 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Locetion - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete June 4 ☐ Donation 5 ☐ Other (Spacify) Lee Crematory 25,1997 Clinton, Maryland 22. Name and Address of Fecility Lee Funeral Home Calvert, P.A. 21. Signature of Funerel Service Licensea 8125 So. Md. Blvd. Owings, Maryland Enter the disease, or complications that blusted the path. Do not antar tha mode of dying, such as cerdiac or raspiratory arrast, or k, or heart feiture. List only one cause on each line. **Physician** PNEUMONIA ASPIRATION /Medicai Immediete Ceusa (Final Brags disaesa or condition resulting in death) Examiner Due to (or es e consequence of) Hospital or Attanding Physician: The law requires that the death certificate be executed
 Abouts after death.
 Funeral Director: After this certificate has been signed by the ettending physician and
 elevity filed in by the intensit director, page 2 should be detached for use es the bunel-trensit ettending physician and for use es the bunel-tren Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in tha underlying ceuse given in Pert I. 23h. Did tohacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown Division of Vital Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 1 Tes 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medicel exeminer? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetlent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 | Homicide 1 Certifying Phyelclen: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) end menner es steted. within 24 hour To the Funer completely fill Medicai 29a. Certifier dical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner steted. 29b. Signature end titla 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) CHARLES JUDGE, M.D. PRINCE FREDERICK, MD. 20678 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State Jahr Studen Radal JUN 24 Registrar

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State of Maryland / Department of Health and Mental Hygiene 97 2 1 4 0

			C	Certificate of	Death	Re	g. No.	
Physicia		Decedent's Neme (First, Middle, Last)				2. Date of Death Month	•	3. Time of Death
/Medica	- 110	JOHN TH	OMAS VICKE	RS		June	30 1997	4:15 p.
Examine	er	e. Facility Neme (If not institution, give street end Dorchester General			tb. City, Town, or Loc Cambrids	ge	4c. County of Death Dorchest	
Funeral Director		6. Sex 214-07-7857 6. Sex 14 M 2	7. Age (In yrs. lest birthd	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, June 24	Year) 9. Birth Cou 1916 Mar	plece (State or Foreig ntry) yland
Maryland H show	tor	Jsual Residence of Decedent 10e. State 10b. County MD Dorchester	10c. City, Town o	r Location ambridge				10d. Inside City Limit
h with the	al Director	Oe. Street end Number 219 Linthicum Driv	е	10f. Zip Code	21613	10	ng. Citizen of Whet Cou	ntry?
urs e	by Funeral	1 Never Married 25 Married 1 X	Decedent Ever In U,S. 1 I Forces? Iss 2 No. WW II Give WW II	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispenIc Origin? (Spe an, Mexicen, Puerto F Specify:	city Yes or No- tican, etc.)	14. Race - Ameri Black, White, Specify: W	
in 72 hours n "natural",	Completed	15. Decedent's Education (Specify only highest grade complete	ed) (G	ecedent's Usual Occup- ive kind of work done of e. DO NOT use retired	during most of working	9 1	6b. Kind of Business/in	dustry
d 2 should be filed within the and Mentel Hygiene. 7 Is marked other then traumstic event, the Mentel Health and the Health and the Health American the Health America	Comp	11	A (3-40r 54)	ent - offi	ce manager		insurance	
S d de le s	To Be	7. Fether's Name (First, Middle, Last)  John Sew	ard Vickers		18. Mother's Name Mint		e <i>iden Sumeme)</i> B. Jam	es
2 sho end h is ma		19a. Informent's Name/Reletionship (Type, Print)	19b. M	ailing Address (Street	end Number or Rural	Route Number,	City or Town, Stete, Zij	Code)
of Health end Mer of Health end Mer Hem 27 Is marks r other traumstic		Mrs. Grace Vickers-wi		9 Linthicu		Cambridg	e MD 21613	
Pages 1 nent of Hu int: If Iten iry or oth	:	0a. Method of Disposition  □ Surial 2 □ Cremation 3 □ Removal fr 4 □ Donation 5 □ Other (Specify)	om Stete 20b. Place of Di cemetery, of Dorches	sposition (Name of cremetory or other place ter Memoria	al Park		Oc. Location - City or To Cambridge M	
permit. Pages Depertment of Important: If I any Injury or once.		21. Signeture of Funeral Service Licensee		22. Name and Address Thomas Fund 700 Locust	eral Home			
ificate be g physicie es the bu	Medical Examiner	mmediete Cause (Finel disease or condition esulting in deeth)  Sequentially list conditions, feny, leading to immediate susse. Enter Underlying cause (Disease or injury hat initieted events esulting in deeth) Lest	Due to (or as e con  Due to (or es e con  Due to (or es e cons  Due to (or es e cons	sequence of):  sequence of):  sequence of):  CA	naled vo	nhave	neulai	10 hr
that the death certified by the ettending deteched for use ex	clan	art II. Other significant conditions contributing t		e underlying cause give	en in Pert I.	23b. Did tob	acco use contribute to	o the cause of deal
	by Phy	Servere elec Septicemia	volyte	abnor.	mality	1 🗆 Yes	2 □ No 3 Pro	bably 4□ Unkno
lew requires es been sign 2 should be	Completed	Septicemia	•			24e. Wes en perform	ed? ev	ere eutopsy finding eilable prior to impletion of cause deeth?
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Physician: this certific ral director,	0	exeminer?	Inpatient 2☐ ER/Outpat	tient 3 DOA Othe	or.		ice 6 Other (Specif	(v)
To the Hospital or Attending Physician: The lew within 24 hours efter deeth.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 ☐ Accident Investigation	te of Injury onth, Dey Year) 28b. Time Injury	e of 28c. Injury			v injury occurred	,,
ital or Attendius effector: Arai Director: Alled in by the fi		determined 286. Pl	ice of Injury - At home, farm, ilding, etc. (Specify)	street, factory, office	2	3f. Location (Stre City or Town,	eet e <i>nd Number or Rura</i> Stete)	al Route Number,
To the Hospital of within 24 hours of To the Funeral D completely filled I	edica	9e. Certifier  (Check only one)  1 ☐ Certifying Physician: To 2 ☐ Medical Examiner: On the end medical Examiner.	he best of my knowledge, de besis of exemination end/or enner steted.	Investigation In my or	sinlon death occurred	det the time dat	e and place, and due to	the course(s)
Withi To the Comp	2	9b. Signeture end IIII of certifier	enez	29c. License	onumber 0569	87	d. Date signed (Month, 6/8D/9)	Dey, Year)
		0. Name end eddress of person who completed c	ouse of deeth (Item 23a) (Type	De, Print)	ora (	sire	ct la	netor
State	е		Registrer's Signeture	Park II			m	21612



				State of Maryla		ent of Health and eate of Death				
			1. Decedent's Name (First, Middle, L	est	Cortino	ato or boatin	2. Data of Dea	eg. No.	3	3. Time of Deeth
	Physici /Medi		Joseph	A. Ward			Month	26 19	Yeer	8:50 py
	Exami		4a. Fecility Neme (If not institution, gi		2.	4b. City, Town, o	r Location of Death	40. County	-	0.00pg
			University of	Maryland to	osp-Jal	1 Ball	more	1	atti,	more
	Funeral			Sax 7. Age (In yrs	Mon	ndar 1 Yaar   If Under 24 Hr	s. 8. Dete of Birth	Year)	9. Birthplace Country)	e (Stete or Foreign
	Director		212 - 54 - 0951 Usual Residence of Decedent	102441 201	Yrs.		03-15	-1950		MD
	filed within 72 hours after death with the Marylend Hygiene. ther than "natural", or items 23s or 28s-1 show int, the Medical Examiner must be notified at		10a. State 101. County	10c. C	Ty, Town or Location	1			10d.	Inside City Limits
		tor	MD Jow	ciset +	lincess	Anne				1 Nas 2 No
	r 28a	irec	10e. Street and Number	1		Zip Code	1	0g. Citizen of V	Vhet Country	?
	th will	al D	36791 Antio	ich Are		21853		L	1.5	
	sens constant	Funeral Director	11. Marital Status	12. Was Decedant Evar in I	U,S. 13. Was D	ecedent of Hispanic Origin? (	Specify Yes or No-		e - American k, White, etc.	
20	or h	by Fu	1 Never Married 2 Married	1 XYes 2 No If Yes, Give		s 2. No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify	-	1
21215-0020	72 hours natural',		3 Widowed 4 Divorced  15. Decedent's E	Yaar or Dates:	16a. Decedent's I	Isual Occupation			$\Theta$ 10	
15	nin 72	Completed	(Specify only highast gi	ede completed)	(Giva kind of	work done during most of we use retired)	orking	16b. Kind of Bu	isiness/indus	iry
21	filed withii Hygiane. ther than	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	SeH	Employe	d	riva	H ( D	nta ctor
pu	0 = 0 =	Be (	17. Father's Neme (First, Middla, Las	"		18. Mother's Ne	eme (First, Middle, i	Meiden Sumam	a)	
Maryland	should be nd Mantai marked o imatic ev	To		aid I.		' Kan	nie L.	Cott	mar	
Mar	2 2 2 2		19a. Informent's Neme/Relationship		1 0 0 00	ress (Straat and Number or F	1)		State, Zip Co	de)
	ges 1 end 2 should it of Heelth and Mar If Item 27 is merke or other traumetic		20a. Method of Disposition	inton Sister	12319	tenlon Cilde	Tinces.	-	MD	21823
Baltimore,	permit. Pages 1 end Depertment of Heelth Important: If Item 27 any Injury or other tr		1 Buriel 2 □ Cremetion 3	Thaillover Ironi State	Place of Disposition ( metary, cremetory		Dete	20c. Location -	1.	State
	permit. Pa Depertmen Important: any injury		4 □ Donetion 5 □ Other (Speci 21. Signature of Funaral Service Lice	-		ICS   Ey Cen	1-1-41	Man	OKin	MY
Ba	Depend Dependent		A A		Ari	and Address of Fecility	ld tun	tal H	one	
	Physician		23e. Pert1. Enter the diseese, or con shock, or heart failure. List enly	policetions thet caused the day	Th. Do not enter that	9 Hampden A	ec or raspiratory err	est An		D 2183
. ,			shock, or heart failure. List-enly	one ceuse on each line.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	or raspiratory on	000	Int	ervel Between nsat end Death
	/Medical		Immediate Causa (Final disease or condition assisting to death)							
	Examiner		resulting in death)		or es e consequence		1-6			OVAN 2
	cate be executed physician end sthe burial-transit	Examiner		, VALVA	uar di	24-4 2-			12	months
		хап	Sequentially list conditions, if any, leading to immediate	Dua to (	or es e consequence	of):				
Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants				cyclist IN	exition		1	day		
68760,		edical	resulting in deeth) Last	Due to (	or as a consequanca	of):				
		2		d						
	death cer e attendir od for use	sicia	Part II. Other significant conditions of	contributing to death but not re-	sulting in the underlyin	ng cause given in Pert f	23h Did to	hacco use cor	tribute to the	e cause of death?
P.0	requires that the de een signed by the a hould be datached f	Physician/M				g data grant are are		s 2 No	3 Probabl	/
	be de d	ě								
Records,	been si should	Completed					24e. Wes e perform		eveilet	eutopsy findings ble prior to
9	S S D	mple			31				of dee	etion of cause th?
- F	cate h						1 □ Ye	s 2 No	1 □ Ye	es 2 No
Vital	rnysician: The lav this certificate has ral director, page 2	Be	25. Wes case referred to medicel exeminer?	Hospital:		Other	eth (Check only on			
ō	r this	5	1 Yes 2 No  27. Menner of Deeth	1 La Inpatient 2 L	ER/Outpetient 3 28b. Time of	DOA   4   Nursing	Home 5 Reside			
o i	th. : Afte	tlor	1 Neturel 5 Pending 2 Accidant Investigatio	28e. Dete of Injury (Month, Day Year)	Injury	28c. Injury et Work? 1 ☐ Yes 2 ☐ No	Zod. Doddrigo no	m injury occurr	ou.	
Division	or Attending effer deeth. Director: Affel In by the fune	Hice	3 Suicida 6 Could not b	28e. Piece of injury - At h	ome, farm, street, fac		28f. Location (St	reat end Numb	er or Rurel Ro	oute Number,
ם :	s effe	Certification:	4   Homicide	building, etc. (Speci	ty)		City or Town	, Stete)		
-	24 hours e Funeral D letaly filled	edicai	29a. Certifier 1 Certifying Ph	yelclan: To the best of my kno niner: On the basis of exemina	owledge, daath occurr	ed et tha tima, data and plec	e, end dua to tha ca	use(s) end ma	nnar as stated	d.
9	to the negation of without of the formation of the formation of the death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page		uno,	end manner stated.						
-	o d ≰i		29b. Signature and title of certifier	n		29c. Licansa number		d. Date signed	-	
			Nuch	( )onse	MD			6/3	1197	,
			30. Name end eddress of person who	completed cause of deeth (Iter	m 23a) (Type, Print)	THERENI	STO	2 - = :	- 7	
	Sta	6	31. Dete filed (Month, Day, Year)	32. Registrer	etute i P	1.1L	UT, BALTI	NURC L	10 6	1021
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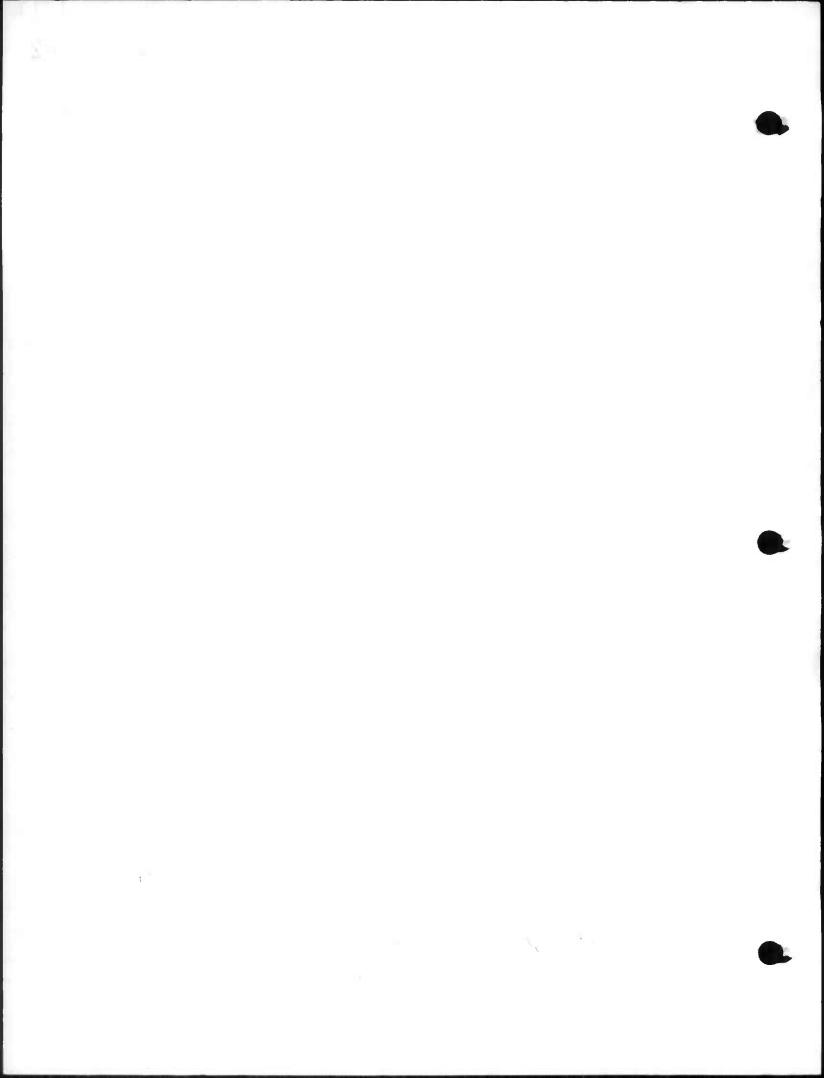
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by the hospital	be detached for use	
6 may be retained	page 5 should	
irs after death. Page 6 m	uneral director,	
hours after de	led in by the fu	, or removal.
be executed within	ician and completely fil	nor to burial, cremation
the death certificat	y the attending phys	d Mental Hygiene p
YSICIAN: The law requires that the death certi	is been signed b	ter death with the State Dept. of Health and Mental I-
PHYSICIAN: The	this certificate his	with the State D
OR ATTENDING !	VIRECTOR: After ti	ours after death
THE HOSPITAL (	THE FUNERAL D	be filed within 72 ha
2	2	90

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

				OLITTI	TOATE	F DEATH	REG. NO	J		
	1	1. DECEDENT'S NAME (First, Middle, Last)  Delmarr L. Wo	22222				2. DATE OF DEATH MONTH June 22,	DAY YEAR	3. TIME OF DEATH	
	10R	4. SOCIAL SECURITY NUMBER 5. SE	X 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEA		7. DATE OF BIRTH (Month, Day, Year)	1997	11745 RTHPLACE (State or Foreign untry)	
9		9a. FACILITY NAME (If not institution, give street and		YRS.			Jan 24 19		chigan	
Z, S SHOUND		Laurelwood Nursing		Center	Elkt	IN OR LOCATION OF DE $O\Pi$	EATH	Se COUNTY O	F DEATH	
es.	DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY		10c. CI1	TY, TOWN OR LO	CATION			10d. INSIDE CITY	
permit. Pages 1,	E	MD Cecil		l F	Rising	Sun			LIMITS?	
E .	AL.	10e. STREET AND NUMBER				101. ZIP CODE		10g. CITIZEN C	F WHAT COUNTRY?	
To a	BY FUNERAL	23 Berkley Rd.				21911		USA		
Telegraphic and the second		1 Never Merried 2 Married IF	AS DECEDENT EVER IID DRCES? 1 1 1 YES YES, GIVE WAR OR D VV 1948-1	2 NO	If yes	Specify Cuban, Mexica (ES 2 1 NO Specify		В	ACE — American Indian, lack, Whita, etc. pecify: White	
use as	9	15. DECEDENT'S EDUCATION		16a. DECEDENT'S			16b. KIND OF BI	JSINESS/INDUSTR		
2		(Specify only highest grade completed Elementary/Secondary (0-12)  Colle	ge (1-4 or 5 +)	IIIe. Do NOT u	· ·	most of working				
once.	BE COMPLET	12	4	Mainte	enance		Medic	al		
at once.		17. FATHER'S NAME (First, Middle, Last)  Lewis Merle Woerner					ME (First, Middle, Maide n Frances			
		19a. INFORMANT'S NAME (Type/Print)		19b MAII INC	ADORESS /Stree		Route Number, City or To			
2	2	Dolores A. Woerner	. Daughte				ng Sun MD			
t pe		20a. METHOD OF DISPOSITION	200	D. PLACE AND DATE	OF DISPOSITION		0	OCATION City or	r Town, Stata	
er must be		1 🔀 Burial 2 🗀 Cremetion 3 🗀 Removal fro 4 🗀 Donation 5 🗀 Other (Specify)		petery, crematory or o benezer	cther place) Cemetei	y June 26	1997 Ri	sing Sun	MD	
or removal.  medical examiner		21. SIGNATURE OF FUNERAL SERVICE LICENSEE	00	1		AND ADDRESS OF FA				
removal.  Bdical examine		R. T. Foard Funeral Home, PA 111 S Queen St. Rising Sun MD 21911								
sician and completery fill prior to bundl, cremation, traumatic event, the	CERTIFICATION		ST. Jude	Mecha a consequence of	nical	AspTic	veys Enlow		i	
giene i	THE	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	OUE TO (OR AS A	A CONSEQUENCE O	hsuff	iciency			3 year	
y, or other	CERTIFIC	cause. Enter UNDERLYING CAUSE (Disease or Injury	OUE TO (OR AS A	A CONSEQUENCE O	hsu F/	iciency			3 year	
Mental Hygiene i	AL CERTIFIC	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART ii. Other significent conditions conti	ributing to death b	but not resulting	in the underl	ying ceuse given in	DEOC		24b. WERE AUTOPSY FINDII	
in Me	DICAL CERTIFIC	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART ii. Other significent conditions cont Coronary Artery	ributing to death b	but not resulting	in the underl	ying ceuse given in	DEOC	ORMED?	24b. WERE AUTOPSY FINDII AVAILABLE PRIOR TO	
of Health and Me	MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other significent conditions cont Coronary Artery Enk - Stare Rena	Disease	but not resulting Diabet	in the underl	ring couse given in	DEOC	ORMED?	24b. WERE AUTOPSY FINDII AVAILABLE PRIOR TO COMPLETION OF CAUS	
of Health and Me thows any inju	MEDICAL	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other significent conditions cont  Coronary Artery  End - Stage Renar  DID TOBACCO USE CON	Disease	but not resulting Diabet	in the underly	ying couse given in lewitus. To	PERFO	ORMED?	24b. WERE AUTOPSY FINDIN AVAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?	
of Health and Me	MEDICAL	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other significent conditions cont  COPONARY AFTERY  FIR -3TAZ Rena  DID TOBACCO USE CON  25. WAS CASE REFERRED TO MEDICAL EXAMINER?	DISCASE  TRIBUTE TO	Diabet  CAUSE OF	DEATH	YES NO	PERFO 1 YES	ORMED?	24b. WERE AUTOPSY FINDIN AVAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?	
the State Dept. of Health and Me or Item 23 shows any inju	HYSICIAN: MEDICAL	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other significent conditions cont  COPONARY AFTERY  FIR -3TAZ Rena  DID TOBACCO USE CON  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  1 1 1	DISCASE  DISCASE  TRIBUTE TO  POTAL: POPULATE OF INJURY	Diabet  CAUSE OF	DEATH  OTHER: 4 Ø Nursing 1	YES NO. PLACE OF DEATH (Chitome 5   Rasidence	PERFO 1 YES	PRMED?	24b. WERE AUTOPSY FINDI AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1  YES 2  NO	
with the State Dept. of Health and Me	PHYSICIAN: MEDICAL	CAUSE. (Disease or Injury that initiated events resulting in deeth) LAST  PART ii. Other significent conditions cont  COPONARY AFTERY  FIR -3TAZE RCNA  DID TOBACCO USE CON  25. WAS CASE REFERREO TO MEDICAL EXAMINER?  1 YES 2 NO  10 HOS	TRIBUTE TO	Diabet  CAUSE OF	DEATH  20 OTHER: 4 Invising I	YES NO. PLACE OF DEATH (Ch.	PERFC 1 YES  1 YES  eeck only one)  6 Other (Specify)	PRMED?	24b. WERE AUTOPSY FINDI AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1  YES 2  NO	
LION: After this certificate has been signed by the after death with the State Dept. of Health and Me 28 is marked, or item 23 shows any injury.	BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other significent conditions cont  COPONARY AFTERY  FIR - STARE RENAMEDICAL EXAMINERY 1 YES 2 NO 1 1 16  27. MANNER OF OEATH 2 Natural 5 Pending 2 Accident investigation	DISCASE  DISCASE  TRIBUTE TO  POTAL: POPULATE OF INJURY	Diabet  CAUSE OF  Patient 3 DOA  28b. Till  Y — At home, ferm,	DEATH  26 OTHER: 4 Nursing I	YES NO PLACE OF DEATH (Cn.  NORTH AT WORK? YES 2 NO	PERFC 1 YES  1 YES  eeck only one)  6 Other (Specify)	INJURY OCCURED	24b. WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?  1 YES 2 NO	
AL UNELLUK: After this certificate has been signed by the 72 hours after death with the State begt. of Heath and Me II Item 28 is marked, or Item 23 shows any injury.	ETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other significent conditions cont  COYONAY AFTERY  FIR - STAR REMA  DID TOBACCO USE CON  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be detarmined  29e. CERTIFIER (Check only)	TRIBUTE TO  SPITAL:  postlant 2 ER/Outs (Month, Day, Year)  186. PLACE OF INJURY building, stc. (Spec	Diabet  CAUSE OF  Pattern 3 DOA  28b. Till IN	DEATH  20 OTHER: 4 Invising Interest, factory, or at the time,	YES NO PLACE OF DEATH (Ch tome 5 Rasidence INJURY AT WORK? YES 2 NO fflice	PERFO 1 YES 1 YES 1 YES  8 Other (Specify) 26d. DESCRIBE HOW 281. LOCATION (Street City or Town, Stah	INJURY OCCURED and Number or Rule)	24b. WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?  1 YES 2 NO	
INE FUNEAL DIRECTOR: After this certificate has been signed by the filed within 72 hours after death with the State Dept. of Health and Me IPORTANT: If Item 28 is marked, or Item 23 shows any injury.	BE COMPLETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other significent conditions cont  COYONAY ATTERY  FIR -3TA3 Rena  DID TOBACCO USE CON  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	TRIBUTE TO  SPITAL:  postlant 2 ER/Outs (Month, Day, Year)  186. PLACE OF INJURY building, stc. (Spec	Diabet  CAUSE OF  Pattern 3 DOA  28b. Till IN	DEATH  20 OTHER: 4 Invising Interest, factory, or at the time,	YES NO PLACE OF DEATH (Ch. NOME 5 Residence INJURY AT WORK? YES 2 NO Interest No. I	PERFO 1 YES 1 YES 1 YES 1 YES 2 Other (Specify) 2 Ed. DESCRIBE HOW 281. LOCATION (Street City or Town, State 1 to the cause(a) and mutime, deta and place, a	INJURY OCCURED  and Number or Rule  anner as stated, and due to the cause  29d, DATE SIGN	24b. WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?  1 YES 2 NO  rel Route Number,  pee(e) and manner as stated NEO (Month, Day, Year)	
THE FUNEAL DIRECTOR: After this certificate has been signed by the filed within 72 hours after death with the State Dept. of Health and Me IPORTANT: If Item 28 is marked, or Item 23 shows any injury.	E COMPLETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other significent conditions cont  C O'O NAVY AFTERY  FIR - 3 TAZE Rena  DID TOBACCO USE CON  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  1 Insula 5 Pending 2 Accident Investigation 3 Sulcide 6 Could not be detarmined  299. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the Control of the Could not be detarmined  299. SIGNATURE AND TITLE OF CERTIFIER Month. To COMM  299. SIGNATURE AND TITLE OF CERTIFIER Month. To COMM  290. SIGNATURE AND TITLE OF CERTIFIER Month. To COMM  30. NAME AND ADDRESS OF PERSON WHO COMM  30. NAME AND ADDRESS OF PERSON WHO COMM  31. NAME AND ADDRESS OF PERSON WHO COMM  20. NAME AND ADDRESS OF PERSON WHO CO	TRIBUTE TO  SPITAL:  nostlant 2 ER/Outs  Res. DATE OF INJURY (Month, Day, Year)  188. PLACE OF INJURY building, stc. (Special to the best of my know the basis of examination  MAD  PLETED CAUSE OF DE	DIAGE  CAUSE OF  Patient 3 DOA  28b. Till  Y — At home, ferm, city)  redge, death occur on and/or investigati	DEATH  20 OTHER: 4 Nursing I AE OF JURY M 1 street, factory, o	YES NO PLACE OF DEATH (Ch. NJURY AT WORK? YES 2 NO Interest No. Intere	PERFO 1 YES 1 YES 1 YES 1 YES 1 Other (Specify) 26d. DESCRIBE HOW 281. LOCATION (Stree-City or Town, State 1 to the cause(a) and mutime, data and place, a MBER 783	INJURY OCCURED  and Number or Rue  anner as stated.  and due to the cause  29d. DATE SIGN  TRANSPORTED  TRANS	24b. WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?  1  YES 2 NO  ral Route Number,  see(e) and manner as stated REO (Month, Day, Year)  2 23,/197	
THE FUNEAL DIRECTOR: After this certificate has been signed by the filed within 72 hours after death with the State Dept. of Health and Me IPORTANT: If Item 28 is marked, or Item 23 shows any injury.	BE COMPLETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other significent conditions cont  COPONARY AFTERY  FIR - STAZE Rena  DID TOBACCO USE CON  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  1 In 1 In 1 In 1 In 1 In 1 In 1 In 1 I	TRIBUTE TO  SPITAL:  POST OF INJURY  (Month, Day, Year)  186. PLACE OF INJURY building, stc. (Special Control of the best of my know the basis of examination  PLETED CAUSE OF DE  2. REGISTRAR'S SIGN	patient 3 DOA  CAUSE OF  Patient 3 DOA  28b. Till IN  Viedge, death occur on and/or investigati  EATH (ITEM 27) (Type  111 WE	DEATH  20 OTHER: 4 Invising Interpretation on the original of the lime, or on, in my opinion on, in my	YES NO PLACE OF DEATH (Ch. NJURY AT WORK? YES 2 NO Interest No. Intere	PERFO 1 YES 1 YES 1 YES 1 YES 2 Other (Specify) 2 Ed. DESCRIBE HOW 281. LOCATION (Street City or Town, State 1 to the cause(a) and mutime, deta and place, a	INJURY OCCURED  and Number or Rue  anner as stated.  and due to the cause  29d. DATE SIGN  TRANSPORTED  TRANS	COMPLETION OF CAUSOF DEATH?  1 YES 2 NO  rei Route Number,  see(e) and manner as stated MEO (Month, Dey, Year)  2 23,/197	



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

			State of Maryland / Departmen  Certifical			entai Hy	rgiene 🥒 1 Reg. No.	Sea 1	143		
	Physic /Medi		Decedent's Name (First, Middle, Lest)     Loretta Combs Wise			2. Dete of De Month	Day	Yeer	3. Time of Death 7:00 PM		
	Exami		4a. Fecility Neme (If not institution, give street end number)	4b. City, Town, or Loc		h 4c. County	. County of Death				
-			St. Mary's Hospital	er 1 Year	Leonardto		St. Ma				
	Funeral Director		577-26-4094 1 M 2 F 76 Yrs. Months		Hours Min.	B. Date of Bil (Month, De February	79, 1921	9. Birthpled Country Mary I	ce (Stete or Foreign and		
	and and		Usuel Residence of Decedent  10e. State 10b. County 10c. City, Town or Location					10d	. Inside City Limits		
	Maryl 1 sho	to	Maryland St. Mary's St. Mary's	City					1 ☐ Yes 2 ■ No		
	h the	Directo	Mark Control of the C	p Code			10g. Citizen of V	Vhet Country	n		
	th wit		General Delivery	20686	6		United S	States			
	r dea	Funeral	11. Marital Status 12. Wes Decadent Ever in U,S. 13. Was Dece Armed Forces? 13. Was Dece If Yes, spe	edent of H	fispanic Origin? (Spe en, Mexican, Puerto F	cify Yes or No	o- 14. Race	a - American			
Baltimore, Maryland 21215-0020	should be filled within 72 hours effer death with the Maryland and Mental Hygiene. I marked other than "naturet; or items 23s or 28s-f show umetic event, the Medical Exeminat must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes Yeer or Deltes:				Specify				
5-0	72 ho	Completed	15. Decedent's Education 16e. Decedent's Usu (Specify only highest grade completed) (Give kind of wo	uai Occup	petion during most of workind)	na	16b. Kind of Bu	usiness/Indus	stry		
121	/ithin ne.	mple	Elementary/Secondary (0-12)   College (1-4or 5+)		d)			. 1 0			
2	Hygiel Her th		12 Postal Cle	erk	40. Mathada Nama		U.S. Pos		ervice		
and	d be f	Be C	William Parran Combs		18. Mother's Name Blanche V			-			
37	shoul nd Me mark imeti	ဥ		s (Street	end Number or Rura				ode)		
Ž	nd 2 eith a 27 is r trau				v. St. Mary's						
ore,	of Herican		20e. Method of Disposition 20b. Place of Disposition (Ne	me of		Date	20c. Location -		n, Stete		
<u>E</u>	Pege net: if int: if		1 ■ Burial 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify)			20-97	St. Mary's	city,	Maryland		
Balt	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Heeith and Mental Hygiene. Department of Heeith and Mental Hygiene Important: If item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other treumatic event, the Medical Examiner must be notitied at once.		21. Signature of Funetal Source Consequent (22. Neme et al., 1800) (22. Neme et al., 1800) (22. Neme et al., 1800) (22. Neme et al., 1800) (22. Neme et al., 1800) (22. Neme et al., 1800) (23. Neme e	nd Addre	ess of Fecility Brins	sfield F	uneral Hon	ne, P.A.	0.0270		
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68760,		edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Also	enera s Engl	lure	tres	13	mo syss		
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	Hospi 4 hou Funer. ely fill	edical	29e. Certifier (Check only of the control of the co	et the tin	ne, dete end plece, e	nd due to the	ceuse(s) end mei	nner es stete	ed. e ceuse(s)		
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			30. Name end eddress of person who completed cause of death (item 23e) (Type, Print)					-			
	12)			RDTO	WN, MD. 206	50					
200	Sta Registr		31. Date filed (Month, Gay, Year)  32. Registrar's Signature  32. Registrar's Signature  Authorities Dawley Randall								

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Division of Vital Records, P.O. Box 68760 or Attending Physician: efter deeth. Director: After this certifica To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by the 24 hours e

7	Cartifying Physical Examine	cian: To the be er: On the basi and manner	s of axamination	edga, daath occu n and/or invastig	rred at tha tima, data and ation, In my opinion, daath	place, and dua to to occurred at tha tim	ha causa(s) and mannar as stateda, data and placa, and dua to tha couse(s)
dille	a of cartifiar	01	/		29c. Licansa number		29d. Data signed (Month, Day, Year)

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AD D06419 6-17-97

30. Name and subjects of person who complated yoursa of death (Itam 23a) (Type, Print) J. Patrick Jarboe, M.D

Leonardtown, MD 20650

State Registrar

cal

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29a. Certifian (Check only one)

29b. Signatura e

Juli Shudan Rardall

32. Registrar's Signatura

**DHMH 16 Rev 6/95** 18

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item #18 WCHD 7/1/97 Em 2. Dete of Deeth 3. Time of Death **Physician** June 30, Del 1997 Yeer CATHERINE VIRGINIA NEWTON WILLIAMS 1325 PM /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** BERLIN WORCESTER ATLANTIC GENERAL HOSPITAL 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth Month, Dev. Year) 7. Age (In yrs. lest birthday) 9. Birthplece (Stete or Foreign **Funeral** Deys Hours 1□M 2□ North Carolina Yrs. 577 26 0690 Director Usuei Residence of Deceden filed within 72 hours after death with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f ehow the Medical Examiner must be notified at Maryland Worcester Ocean City 1√2 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 9001 E. Biscayne Dr. 21842 U.S.A. 12. Wes Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No altimore, Maryland 21215-0020 1□ Yes 2√No Specify: þ White 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry el Hyglene. Elementery/Secondary (0-12) College (1-4or 5+) 9 Hairdressing Industry Beautician 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be pemit. Pages 1 and 2 should be i Department of Health end Mentel I moortant. If Itom 27 to marked of Henry C. Newton Mae Elizabeth (Unknown) Abernathy 19a. Informant's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Thomas A. Moody 3309 Elk Creek Rd. Mineral, VA 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 XCremetion 3 ☐ Removel from State Cape Henlopen Crematory 7/1/97 Frankford, DE 4 ☐ Donetion 5 ☐ Other (Specify) 108 William Street Service Licenses 22. Name end Address of Fecility Burbage Funeral Home Berlin, MD Thetale bisees, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel arcinoma diseese or condition resulting in death) **Examiner** Due to (or es e consequence of): Examiner Paeamonia. physicien end s the buriel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that Initieted events resulting In deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): ettending p e s signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No Probably 4 ☐ Unknown δ 24b. Were eutopsy findings evailable prior to completion of cause of death? Completed 24a. Wes an eutopsy ate hes b ils certificate h director, page 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 □ ER/Outpetient 3 □ DOA After this funeral Certification: 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident rector: 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after 4 | Homicide 24 hours Test Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner steted. 29e. Certifier To the Hosp within 24 hor To the Fune completely fi edicai (Check only one) 29b. Signature and title.pl 29d. Date signed (Month, Dey, Year) 29c. License number 00050605 June 30 aus 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

2 - CHRISTIE MD

9733 Healthway Dr

Healthway

32. Registrer's Signature

Januar Randall

Berlin

Md 21811

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State

31. Date filed (Month, Dey, Year)

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State of Maryland / Department of Health and Mental Hygiene

				Certifica			, ,	eg. No.		
Physic /Medi		1. Decedent's Name (First, Middla, Las	William	s. Sr.			2. Date of Dea Month	Dey 24,19	Yeer	3. Time of Death
Exami		4e. Facility Name (If not institution, giva	straet and numbar)		41		Location of Death	4c. County	of Death	
Funeral Director		PENINSULA REGION.  5. Social Security Number  6. Security Number  Usual Residence of Decedent			ler 1 Year s Days	SALISB If Under 24 Hrs Hours Min	8. Date of Birth	WICO	9. Birthpla	ace (Stata or Foraigr y)
Maryland Incom	tor	10e. State 10b. County	1	ity, Town or Location	Sp (	City			10	d. Inside City Limits
th with the 23a or 28a	Funeral Director	10e. Steet end Number	Street		Zip Code	51	1	Og. Citizen of V	Vhat Countr	y?
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mostcal Examination must be notified at	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Dacedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, sp	edent of His becify Cubar 2 2 No	spanic Origin? (S n, Mexican, Puer Spacify:	Specify Yes or No- to Rican, etc.)		e - America ck, White, et	
21215-0020 d within 72 hours eff gjene. r then "natural", or r the "eoical Exam	Completed	15. Decedent's Edi (Spacify only highast gred Elementary/Secondary (0-12)	cation fe complated) College (1-4or 5+)	16a. Decedent's Us (Giva kind of white DO NOT) Painte	vork dona d use ratired)	tion uring most of wa	rking	16b. Kind of Bu	usiness/Indu	stry
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re, Mar 1 and 2 sh Health and tem 27 is m other traum		19a. Informant's Name/Relationship (T) Virginia Williams 20a. Method of Disposition	/ wife	19b. Mailing Address 1903 Brown Place of Disposition (A	ama of	St., Poc	omoke	City or Town,  20c. Location -	2185	51
Baltimore, bermit. Pages 1 a Department of Hee mportant: if Nem my injury or othe	}	1	Temoval from State		ist C	emeten s of Facility	6-27-97	Pocomo		md.
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he Hosp in 24 ho he Fune pletely f	edica	29a. Certifier (Check only one)  Certifying Physical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	wiedge, death occurre tion and/or investigation	d at the time n, in my opl	e, date end place nion, death occu	, end due to the ce irred et the time, de	use(s) end me ete end place, a	nner as stet and due to th	ed. ne ceuse(s)
To t withi To t	Σ	29b. Signature and title of dertifier	uf		ec. License	00-		Od. Date signed	(Month, De	oy, Year)
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State of Maryland / Department of Health and Mental Hygiene	9	7	21	1	L

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30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)  Bsher A. Touleimat, MD 9733 Healthway Dr. Berlin, MD 21811  State 31. Data filed (Month, Day, Year) 32. Begistrar's Signature		othio ompl		29b. Signature and title of ce	rtifier		7_		29c. Lic	ansa number		- 2	29d. Date signe	d (Month, L	Day, Year)	
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)  Bsher A. Touleimat, MD 9733 Healthway Dr. Berlin, MD 21811  State 31. Data filed (Month, Day, Year) 32. Begistrar's Signature		⊢ s ⊢ ŏ		VOBON	1	ala	2	-	DV	2626			6/21	1/21		
Bsher A. Touleimat, MD 9733 Healthway Dr. Berlin, MD 21811 State 31. Data filed (Month, Day, Year) 32. Degistrar's Signature				20 NAme and additional	U	~~~~~	of death in	000 7	200	707			10	127		
State 31. Data filed (Month, Day, Year) 32. Begistrar's Signature			10							_						
Registrar JUN 2 7 1997 John Studior Radell			X	31. Data filed (Month Day V	l ou	ieimat,	MD 9	/33 He	althway	Dr. Be	erlin,	, MD	21811			
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State of Maryland / Department of Health and Mental Hygiene

				Ce	rtificate of	Death		g. No.		
Physic	ian	Decedent's Name (First, Middle,					2. Dete of Deat Month	h Dey	Year	3. Time of Death
/Medi		ALFRED EUGE					JUNE	24, 1	997	5:50 AM
Exami	ner	4e. Fecility Neme (If not institution,				4b. City, Town, or L		4c. County		
ALC:		PRINCE GEORGE	S HOSPITAL	CENTER		Cheve	rly	Prince	Geo	rge's
Funeral Director		577-58-9913	6. Sex 7. A 1 ☑ M 2 ☐ F	ge (In yrs. lest birthday, 51 Yrs.	Months Days		8. Date of Birth (Month, Dey, Dec. 16			iace (State or Foreign try) ngton, D.C.
aryland show		Usuei Residence of Decedent 10a. State 10b. County		10c. City, Town or L					10	Od. Inside City Limits
8a-f	5		George's	S	eat Pleas	sant				1 ☐ Yes 2 ☐ No
th with the 23a or 2 unit be no	Funeral Director	10e. Street end Number 6233 Addison Ro	oad		10f. Zip Code	20743	10	Og. Citizen of V Unite		•
72 hours efter death with the Maryland "natural", or items 23a or 28a-f show ideal Examiner must be notified at	by	11. Maritel Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Wes Deceden Armed Forces d 1  Yes 2   If Yes, Give Year or Dates:	No	Was Decedent of I If Yes, specify Cub 1☐ Yes 2☐ No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Specify		
within ene. than "	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grede completed)  College (1-4or	5+)		petion during most of work d) chnician	ing	16b. Kind of Business		
e filed other vent, I		17. Father's Neme (First, Middle, La	ast)	Fla	IIIOOM IE	18. Mother's Nam	e (First Middle N			
d be entel	Be C	Robert L. Was					E. Brown		-/	
d 2 should by the nd Mente 7 is marked traumatic ev	2	19a. Informant's Name/Reletionshi		10h Maili	no Address (Street	end Number or Rur			Cinto Tin	Codel
		Thelma B. Washi				Road, Sea				
Peges 1 end 1 nent of Heelth nt: If Item 27 iny or other tr		20a. Method of Disposition 1 ☑ Buriai 2 ☐ Cremetion 3	B □Removel from State	20b. Placa of Dispo cametery, cre	osition (Neme of matory or other ple	ca)	Date 2	20c. Location -		
ft. Po		4 □ Donetion 5 □ Other (Spe			oln Cemet		27/97	Brentwo	od, N	1D
permit. Pege Department of Important: If any Injury or once.		21. Signeture of Funeral Service Li	Stumment	T S		ess of Fecility JNERAL HON ing Road,	•	achinat	on I	o.c.
Physician /Medical		23a Enter the disease, or concern the concern that concern the concern	(3)	d the death. Do not en ine.	ter the mode of dyli	ng, such es cerdiac	or respiretory erre	est,		Approximete Intervel Between Onset end Death
Examiner	10	diseese or condition resulting in death)	· Septic	Due to for as a conso	quence of):	- 800	W		1	week
ecuted and transit	Examiner	Sequentially list conditions,	b. 18C	Duo to (or as a conso	repatit	45	pw		4	week
tificete be executed g physician and es the buriel-transit	edical E	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Lest	e. End.	Stage Yen	al faul	une	zjow)		1	months
* O 0	Physician/Me		· Pulmo	nary ede		to Volu	me or	enloa	201	months years
deal	SICI	Part <sub>i</sub> ll. Other significant condition	e contributing to death t	out not resulting in the u		ven in Pert I.		ecco use cor		the cause of death?
es thet the death certigned by the ettendin be deteched for use	by Phy	Mo Seizure d	BORDER				1 🗆 Ye	s 2 No	3 Prob	ably Munknown
aw requir	Completed 1	Mo Seizure d pancreati	+15				24a. Was er perform		ava	re eutopsy findings ileble prior to appletion of cause leeth?
	Sol						1 □ Ye	s 25 No	1 🗆	Yes allo
Physician: The this certificate ral director, pag	Be	25. Wes case referred to medical examiner?				26. Plece of Deat	n (Check only one	9)		
O O	2	1 ☐ Yes ZXÎ No	Hospitel:	ent 2 ER/Outpetier	nt 3 DOA Oth	ner: 4□ Nursing Ho	me 5 Reside	nce 6 Othe	er (Specify	)
After fune		27. Menner of Death  1 Naturei 5 Pending 2 Accident investigat	28e. Dete of inju (Month, De	28b. Time of Injury	Wor	y et rk? Yes 2 □ No	28d. Describe ho	w injury occurr	ed	
al or Attended setter deet I Director: id in by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	ad 289. Pieca of in	jury - At home, farm, str c. (Specify)	eet, factory, offica		28f. Location (Str. City or Town,		er or Rural	Route Number,
P Hospital 24 hours Funeral letely filled	edical (	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best aminer: On the basis of end manner st	of my knowledge, deetl f examination end/or in ated.	n occurred et the tirvestigetion, in my o	me, dete end plece, pinion, death occurr	end due to the ce ed et the time, da	use(s) end me te end place, e	nner es ste end due to	eted. the ceuse(s)
100	Me	29b. Signature end title of cartifier			29c. Licens	e number	29	d. Dete signed	(Month, D	Pey, Yeer)
8		Jes Dixo	n Webbe	ND	D4	4518		6/2	4/9	7
		30. Name and eddress of person wh	o completed cause of		Print)	spital 1	00	/		en h
Sta	te	31. Dete fiied (Month, Day, Year)	32. Regist	rer's Signeture	3001 Ho	spilar 1	in. W	ENTRE	411	1.0

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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 25, **Physician** Day 1997 Year Anne Elizabeth Wade 10:45 PM /Medical 4b. City, Town, or Location of Death 4e. Facility Name (If not Institution, give street end number) 4c. County of Death **Examiner** Doctors Community Hospital If Under 1 Year If Under 24 Hrs. Prince George 5

9. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 25 F Days Hours Yrs. 223-12-8504 76 Director Oct. 13, 1920 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland | Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Items 23a 4711 Berwyn House Road #311 20740 U.S.A. Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 8 White 1 ☐ Yes 2 No Specify: δ 3 Nidowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Nannie Fletcher Steppe Artie Royal Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) If Hem 27 is Brenda A. Manis - Daughter 9612 Van Buren Street, Seabrook, Maryland 20706 Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 6/28/97 4 ☐ Dorlation 5 ☐ Other (Specify) Brentwood, Maryland Fort Lincoln Cemetery 21. Signalur of Funeral Service License 22. Name and Address of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, or heart failure. List only one ceuse on each line. **Physician** narghiac arres /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner buriel-trensit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and nding physician ause es the buriel-P.O. Box 68760, Physician/Medical Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably been signed t Records, by 24b. Were autopsy findings eveilable prior to completion of cause of death? 24e. Wes an autopsy performed? Completed 1 ☐ Yes 2 ☐ No Division of Vital o the Hospital or Attending Physician: ithin 24 hours after death. b the Funeral Director: After this certifica Be 25. Was cese referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Medical Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Drive, Berry uninghan 31. Date filed (Month, Day, Year) State JUN 27 1997 Registrar

			State of Maryland	Certificate of			giene	21	150	
ı	Physici	an	1. Decedent's Name (First, Middle, Last)  Charlie O. Willia			2. Dete of De Month	Day	Year	3. Time of Death	
d	/Medi Examir	cal	Charlie O. Willia  4a. Fecility Neme (If not institution, give street end number)		4b. City, Town, or Lo	June			11:04 AM	
1	LAGIIII	161	Doctors Community Hospital		Lanham			e Geo	raes	
	Funeral Director		5. Social Sacurity Number 245-01-9792 6. Sex 120 M 2□ F 7. Age (In yrs. last	t birthday) If Under 1 Yaar Months Deys	If Undar 24 Hrs. Hours Min.	8. Dete of Bir (Month, De	th y, Year)	9. Birthplac	ca (State or Foreign h Carolin	
	and with		Usual Residence of Decedent  10a. State 10b. County 10c. City, T	Fown or Location					. inside City Limits	
	with the Maryland a or 28a-f show be notified at	to	Maryland Prince George's	Rive	rdale			1.22	1 TYPes 2 □ No	
0	or 28	Directo	10e. Straat and Number	10f. Zip Code			10g. Citizen of W	hat Country	?	
	death w		6801 Emerson Street	10 111 5 1 1 1	20737			SA		
21215-0020	72 hours after do natural, or Nem ilical Examiner	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Dacedent Ever in U,S. Armed Forcas?  1 Yes, Give Year or Detes:	13. Was Decedent of H  If Yas, specify Cubi  1 ☐ Yes 2 ☐ No	an, Mexican, Puerto Specify:	ecify Yas or No Rican, etc.)	Specify:	- American k, White, etc B1a		
5-0	72 ho 'natur dical	Elementery/Secondary (0-12) College (1-4or 5+)					16b. Kind of Bus	siness/Indus	stry	
121	within ene. than 7						Dr	ivate		
	<b>新表表</b>	Be Cc	8th 17. Father's Neme (First, Middla, Last)	Printer	18. Mother's Name	(First, Middla,				
Maryland	ahould be ind Mental imarked o	ToB	Jack Dallas Williams		C	Seneva	Jones			
Mar	2 sho and is m							Stete, Zip Co	ode)	
	ges 1 and t of Health If Hem 27 or other tr			o of Disposition (Name of etery, cramatory or other plea		Riverda	neva Jones  oute Number, City or Town, Stete, Zip Code)  verdale, MD 20737  Dete 20c. Location - City or Town, Stete  /23 Landover, Maryland  1 Home Landover, MD 20785			
Baltimore,	8 0 = b		I DADUNAL 2 LICIONALION 3 LINONIOVALIONI SIALE	etery, cramatory or other plea ony Memorial	D .	6/23 997				
alti	permit. Pa Departmen Important: any injury.		21. Signeture of Funeral Service Licensee	22. Name end Addre	ss of Fecility			•		
ш_	86253		Nancy A. Percentie	l. Land	over. MD	20789	5			
			23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.	Do not enter the mode of dyin	ng, such es cerdiac o	or respiretory a	rast,	Ar	pproximate terval Between	
	Physician /Medical		Immediate Cause (Finel	ntatus Disanta						
	Examiner		resulting in deeth)	tery Disease se consequence of):				10	v years	
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Ć,	icete be executed physician end s the buriel-transit	Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury c.	s a consequence of):						
68760,	ste be nysicia he bur	edical		a consequence of):	-		ast, Approximate Interval Between Onsat and Death			
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Box	eath certific ettending p	Physiclan/M								
P.O.	es that the de igned by the e be detached t	hysi	Part II. Other elgnificent conditions contributing to deeth but not resultin	ig in the underlying cause giv	en in Pert I.	23b. Did 1	· · · · · · · · · · · · · · · · · · ·		e cause of death?	
	es tha igned be de	þ	Hypertension						.,	
Records,	aw requii as been s 2 should	Completed				24a. Was perfo	en eutopsy rmed?	availe	eutopsy findings ble prior to letion of cause ath?	
E R	The ete h	Con				101	res 200	1□Y	es 2□ No	
Vital	Physician: The this certificate ral director, per	o Be	25. Was cese referred to medical exeminer?  Hospitel:   Hospitel:	Outrotion 3 DOA Oth	26. Place of Death					
of	y Phys eral di	-	27. Manner of Deeth 28e. Date of Injury 28	b. Time of 28c. Injur	4 LI Nursing Hor		tence 6 □Othe now injury occurre			
ion	Attending For deeth.  Sector: After by the funer	atlo	1 Alatural 5 Pending (Month, Dey Yaar) 2 Accident investigation		Yes 2□No					
Division	al or Attendir s efter deeth. Il Director: Af ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office		28f. Location (3 City or Tox	Street end Numbe vn, State)	r or Rurel R	oute Number,	
	To the Hospital or A within 24 hours effer To the Funeral Dire completely filled in b		29a. Certifier Certifying Phyelclan: To the best of my knowled	dge, death occurred at the tin	ne, date end plece, a	and due to the	cause(s) and mer	ner as stete	ad.	
	he Ho in 24 h he Fui pletely	edical	(Check only Definition one) Medical Examiner: On the basis of examination and manner stated.	end/or Investigetion, in my o	pinion, deeth occurre	ed et the time,	date and place, a	nd due to the	e cause(s)	
	With To t	Σ	29b. Signature and the of confident	29c. Licens	e number		29d. Date signed			
	(1)		1 Copyant S		20989		June 2	0, 19	97	
	(0)		30. Name end address of person who completed author death (Item 23 Elwood Holland, MD 6005 Land	le) (Type, Print) Lover Road, St	uite 3. Cl	reverlu	MD 20	785		
	Sta	_	31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature			- DI C Deg	, 20			
	Registr	ar	JUN 24-1997 July Dunbard	4464						

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State of Maryland / Department of Health and Mental Hygiene 9 7 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year **Physician** Bobbie Wood 1997 JUNE 18 2052 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY
If Under 24 Hrs. 8. Data of 5. Social Security Number If Undar 1 Yaar 7. Age (In yrs. lest birthday) 8. Data of Birth (Month, Dey, Year) Birthpleca (State or Foreign Country) **Funeral** 1 M 2 X F Days Hours Yrs. 58 578-54-4532 Director March 7, 1939 South Carolina Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits Items 23a or 28a-f short Instrument be notified at 1 ☑ Yes 2 ☐ No Director Maryland Prince George's Forestville 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 20747 2618 Timbercrest Drive U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Maritel Status traumatic event, the Mudical Examiner 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0020 ò 1 ☐ Yes 2 ☑ No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Peges 1 end 2 should be filed within Depertment of Health and Mentel Hygiene Important: If itam 27 is merked other than any injury or other traumetic avens Elementery/Secondary (0-12) College (1-4or 5+) Private Telephone Operator 11th 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Wilkins Helen Foster Othe1 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2618 Timbercrest Drive, Forestville, Maryland 20747 Thomas E. Wood/Husband 20b. Place of Disposition (Name of cemetery, crametory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 06/24 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Harmony Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) 1997 Landover, Maryland 21. Signature of Funerel Service Licensee J. B. JENKINS FUNERAL HOME Percen 7474 Landover Road, Landover, Maryland 20785 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart faithre. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediete Causa (Final diseesa or condition resulting in death) Examiner neumonia that the death certificate be executed the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last pue Due to (or es e consequence of): mmunusuppression P.O. Box 68760, physician Physician/Medicai Imonar Sarcoidosis Pert II. Other eignificent conditione contributing to death but not rasulting in the underlying cause givan in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown ۾ 1 ☐ Yes 2 ☐ No Ventricular. been signed to should be dete Records, 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes an eutopsy performed? Be Completed certificete 1 ☐ Yes 2 ☐ No Division of Vital Hoapital or Attanding Physician: 24 hours efter deeth. Funaral Diractor: After this certifice stely filled in by the funeral director; 25. Was case referred to medical exeminer? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1. Watural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicida 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 4 Homicide n 24 hour. 12 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the ceuse(s) end manner stated. 29a. Certifier To the Hoap within 24 hou To the Funal completely fil Medical 29b. Signature and title of certifie 29c. License number Medicine Resident

Tower Building 600 North Holfe Street Baltimore

State Registrar 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

32 Registrer's Signeture

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Blankson MD

31. Dete filad (Month, Day, Year)

**DHMH 16 Rev 6/95** 

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State of Maryland / Department of Health and Mental Hygiene 2 | 1 | 5

Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** SYLVANIA W. WOODS. SR. 1997 June. 21 8:55AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Prince Georges 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 100 M 2□ F Yrs 69 Director 257-20-2712 08-04-27 Georgia Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 28a or 28a-f show other traumatic event, the Maxical Examinar must be notified at 10d. Inside City Limits Prince George's Maryland Glenarden tXXYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7816 Fiske Avenue 20706 USA deeth 12. Was Decedent Ever in U,S.
Armed Forces?

1 20 Yes 2 2 No 4/2/43
If Yes, Give to 12/13/45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 20 Married 1 ☐ Yes 2 X No Specify: Black ð 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 end 2 should be filed within 72 hours Department of Heelth and Mental Hygiene Important: if Item 27 is marked other than "natural!, any injury or other traumatic event, the Madical Example. 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Judge Government Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Andrew Woods Cora Mathis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geneva Woods/Wife 7816 Fiske Avenue, Glenarden, Maryland 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 06/27 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Ceme. 1997 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J.B. Jenkins Funeral Home Percentes Nancy 7474 Landover Road, Landover, Maryland 20785 23a. Part 1. Enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Severe beverlie celor heart fadere

Due to (or es a consequence of):

Chierie renal facilere

Due to (or as a consequence of): ettending physician and for use as the buriel-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Physician/Medical Uncelin Opendan signed by the et Part II. Other signiffcant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 Unknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medicel Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this 27. Manger of Deeth ie Hospital or Attending Pl n 24 hours efter death. ie Funeral Director: After th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO8520 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) T-6 Greenbett mo Greenway Dr. Tomas Hernandez 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar

Vo. 1. & - .

B.K.S State of Maryland / Department of Health and Mental Hygiene PHILLIP YUNGER Certificate of Death Items: 23a part I, 27, 28a-f per MEO G-749 7/14/97 dh

Physician
/Medical
Examiner

W. YUNGER PHILIP

3. Time of Deeth 0654AM

1 XYes 2 No

**Funeral** 

the Maryland

Director

Director

Funeral

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Completed

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Examiner

Physician/Medical

by

Completed

Be

2

Certification:

Medical

29a. Certifier

(Check only one)

filled in by

24 hours a

To the Hosp within 24 ho To the Fune completely f

7 is marked other than "neturel", or items 23e or 28a-f show treumstic evant, the Medical Exeminar must be notified at death 2 should be filed within 72 hours efter on and Mentel Hygiane.
Is marked other than "neturel", or item permit. Pages 1 and 2 sl Depertment of Haalth en Important: if Item 27 is n any injury or other treur

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

ician and burial-trensit physician s the burial Box 68760. 80 use Use signed by the e P.O. Records. should should certificete Division of Vital this funeral I or Attanding Fafter deeth.

Diractor: After After

1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth JUNE 27, Day 1997 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 10008 REDDICK ROAD SILVER SPRING MONTGOMERY ff Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Months | Devs | Hours | Min. | (Month, Dey. 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Deys ₩ M 2□ F WASHINGTON, D. 24 003 64 1502 Yrs OCT 1,1973 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits D.C. NONE WASHINGTON, D.C. 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20017 USA 1406 NEWTON STREET N.E. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 □XNever Married 2 □ Married 1□ Yes 2□ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) THEATHER STAGE HAND yr. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) JONES PHILIP G. YUNGER BARBARA 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) PHILIP G. YUNGER (FATHER) 1406 NEWTON ST.N.E. 20b. Place of Disposition (Neme of cemetery, cremetory or other) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RIVERDALE CREMATORY JUN 28,1997 RIVERDALE 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility RALPH WILLIAMS FUNERAL SVC 517 11th STREET S.E. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Bety Onset end Death Immediate Cause (Final NARCOTIC AND METHAMPHETAMINE INTOXICATION disease or condition resulting in death) Due to (or as e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or as e consequence of): Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed?

1 Yes 2 □ No Yes 2□ No 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) XX es 2 □ No 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Naturel 1 ☐ Yes 2 (No 2 Accident found: 6/27/97 unknown unknown 6 ChCould not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 0008 Reddick, Silver

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Spring, Md. 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as stated. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated.

29b. Signature end title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

JUNE 27, 1997

Radentz, M)111 Penn Street, Baltimore, Maryland 21201 Stephen 31. Dete filed (Month, Day, Yeer)

O.C.M.E

State Registrar

32. Registrar's Signeture

**DHMH 16 Rev 6/95** 

6/30/97 Carroll Co. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** JUNE 1997 ZEPP AUIS ELIZABETH /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Saint Joseph Medical Center Towson Baltimore If Undar 24 Hrs. Hours Min. If Under 1 Year Months Days 7. Aga (In yrs. last birthday) Birthpleca (Steta or Foraign Country) **Funeral** 1 ☐ M 2 🖫 F Yrs Director 212-05-1027 79 March 21, 1918 Usual Rasidanca of Dacedent the Maryland 10b. County Baltimore 10a. State 10c. City, Town or Location 28a-f ahow 7 is marked other than "natural", or itams 23a or 28a-f aho traumatic event, the Medical Examinat insit to notified at Director - Carroll Upperco 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 5712 Emory Road Funeral 21155

13. Was Decedent of Hispanic Origin? (Specify Yas or NoIf Yas, specify Cuban, Mexican, Puarlo Rican, atc.) 14. Hace - Amarican Indian, 12. Wes Dacedant Evar in U,S. Armed Forcas? 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or itan any injury or other traumatic event, the Medical Examinat once. Black, Whita, atc. 1 Navar Marriad 2 Marriad 1 ☐ Yas 2 📉 No If Yas, Giva Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White by 3 Widowed 4 ☐ Divorced Yeer or Datas: Completed 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) Elementery/Secondery (0-12) College (1-4or 5+) Elementary Education 12 Teacher 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) Charles Arthur Butts Elsie Markle 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, Stete, Zip Coda) Mr. William Zepp (son) 5710 Fmory Road Upperco, MD 21155 ca of Disposition (Nama of Data 20c. Loca 20b. Placa of Disposition (Nama of cemetery, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Spacify) Evergreen Memorial Gardens 6/27 Finksburg, MD 21. Signatura of Funaral Sarvice Licensee 22. Nama and Address of Facility HAIGHT FUNERAL HOME & CHAPEL (Box 195) Brian Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immadiata Causa (Final disease or condition rasulting in death) ACUTE MYOCARDIAL INFARCTION /Medicai **Examiner** Dua to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Diseasa or injury that initiated avants rasulting in deeth) Last Due to (or as a consaguança of) Box 68760. Dua to (or as a consequence of): attending p USB P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. the 23b. Did tobacco usa contributa to the cause of death? signed by t 1 Yas 2 No 3 Probably 4 Unknown

Physician/Medical þ Completed Be

25. Was casa referred to medical axaminar? Hospitel: 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA

24b. Ware autopsy findings available prior to complation of cause of deeth? 24a. Was an autopsy parformad? 1 Yas 2 No 1 ☐ Yas 2 No 26. Place of Death (Check only one) Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 8 ☐ Othar (Specify) 28d. Describe how injury occurred

27. Mannar of Daath 1 Natural 2 Accident 3 Suicida 4 Homicida

5 Panding invastigation 6 Could not be datarminad 28e. Data of Injury (Month, Day Year) 28b. Time of 28a. Place of Injury - At home, farm, straat, factory, offica building, atc. (Specify)

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28f. Location (Street and Number or Rural Routa Number, City or Town, Steta)

29a Cartifiar

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) end manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceusa(s) and mannar statad.

29b. Signatura and titla of certifian

29c. License number D 16492

29d. Data signed (Month, Day, Year)

3. Time of Death

10d. Insida City Limits

Approximate Intarval Batween Onsat and Deeth

48 HOURS

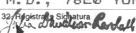
1 Yas 2 No

11:10 AM

30. Nema and addrass of person who complated cause of death (Itam 23a) (Type, Print)

P. M. D., BEATRIZ 7620 YORK ROAD, TOWSON, DIZON, MD. 21204

State Registrar



Division of Vital Records,

should

pege 2 has

Certification: To

cal

certificate

a Hospital or Attending Physician: 124 hours efter death. • Funeral Director: After this certifica letely filled in by the funeral director,

To the Hosp within 24 hou To the Funer completely fil

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Iteml 8-4-97 FilmG750 W.H.Per Doctor Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth 3. Time of Death **Physician** E 1. Armstrong Month David 440Am 10 97 /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore, Johns Hopkins Baywell Medical Contes MD If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 1 Ø M 2 ☐ F 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 215-66-4908 17 1957 MARYLAND Usuel Residence of Decadent permil. Pegas 1 and 2 should be filed within 72 hours effar death with the Maryland Department of Health and Martial Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, fre Medical France. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director MARYLAND N/A BALTIMORE CITY 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Completed by Funeral 4836 BOWLAND AVENUE 21206 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 1 X Never Married 2 ☐ Married BLACK 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WELDER BETHELHEM STEELE 12vrs 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be JOSEPH ARMSTRONG, JR. MELBA PRESTON 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21239 19a. Informant's Neme/Relationship (Type, Print) Melba P. Armstrong/Mother 6401 Loch Raven Blvd, Apt 301, Baltimore, Maryland 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetery or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State HOLLY HILLS MEM. GARDENS 07-15 MIDDLE RIVER, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral 55 22. Name end Address of Fecility WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heer failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Final Liver Failure disease or condition resulting in death) **Examiner** Examiner pital or Attending Physician: The law requires that the deeth cartificate be executed ours after death.

eral Director: After this cartificate has been signed by the attending physician and filled in by the funated director, page 2 should be deteched for use as the burshet mast Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760. Physician/Medicai Due to (or as a consequence of) signed by tha a Pert II. Other significant conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) Hospital: 1 ⊠Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 28a. Dete of Injury (Month, Dey Year) Certification: 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Tyes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

To the Hospital o within 24 hours af To the Funeral Di

Medicai complately State Registrar

John TenBreich unD 31. Date filed (Month, Day, Year)

29b. Signeture and title of cartifier

WestrockMA

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

29a. Certifier

4940 Eastern Ave. Baltimor MD 21224 32 legistrer's Signature his Davidson

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) end menner stated.

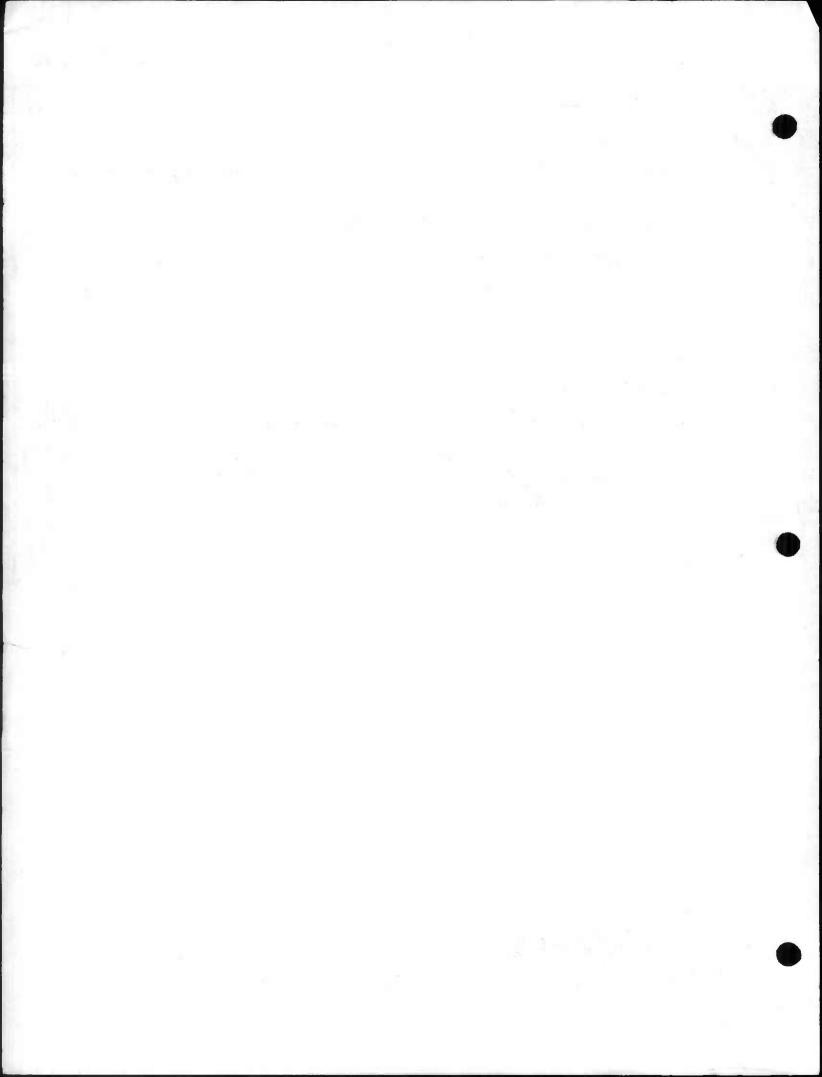
29c. License number

96117

29d. Date signed (Month, Day, Yeer)

147

**DHMH 16 Rev 6/95** 



Item5 8	22-97 FilmG750 W.H.Per	State of Maryla
	1. Decedent's Name (First, Middle, Last)	
Physician	MADV AT	TEN

8	-22-97 FilmG750 W.H.Per	State of M	aryland /	Departm Certific					iene g	7	21156
	1. Decedent's Name (First, Middle, Las	st)						2. Dete of Deeti			3. Time of Deeth
an	MARY A	LLEN					]	JULY 7	7, 1997	Yeer	11:15 P.
al	4a. Fecility Name (If not institution, give	e street end number				4b. City. To	own, or Loc	ation of Deeth	4c. County		
er											
	LIBERTY MI 5. Social Security Number 6. S	T	ENTER ge (In yrs. last i	hirthday) If Ur	der 1 Yea	BAI r If Under	TIMO	8. Date of Birth	N/		halaaa (Class or Farrian
		DM 2DE		Yrs. Mont		Deys Hours Min. (Month, Dey, Year)				Co	hplece (State or Foreign untry)
	Usual Residence of Decedent	X	64					DEC. 29	1932	PEN	NSYLVANIA
	10a. State 10b. County		10c. City, To	wn or Location							10d. Inside City Limits
7	MD. N/A		BAI	TIMOR	7						1 □ Yes 2 □ No
oct			DAI								21
<b>Funeral Director</b>	10e. Street end Number			10f.	Zip Code			10	g. Citizen of 1	Whet Co	untry?
a	2835 PRESBURY S	STREET			2	1216			U.S.	OF	Α.
nei	11. Maritel Status	12. Was Decedent Armed Forces?	Ever in U,S.	13. Was De	cedent of	Hispenic Or	rigin? (Spe	cify Yes or No- Ricen, etc.)	14. Rad	e - Amei	rican Indien,
丑	1 Never Married 2 Married	1 ☐ Yes 2 🔽						ilogii, etc.)		ck, White	e, etc.
by	3 Widowed 4 □ Divorced	If Yes, Give X Year or Dates:		1 □ Ye	s 2 No	Specify	<i>'</i> :		Specify		ACK
ted	15. Decedent's Ed	lucetion	16	ie. Decedent's L	suel Occi	pation		1	6b. Kind of B		
ple	(Specify only highest gre- Elementary/Secondary (0-12)		F.()	(Give kind of life. DO NO	work don Tuse retir	e du <i>ring</i> mo: ed)	st of workin	ng .			
Completed by	10 TH	College (1-4or		SEAMSTI	DECC			C	PLITNO	TZ A	CTODY
	17. Fether's Name (First, Middle, Last)			PEARIOLI	CEOO	18. Moth	er's Neme	(First, Middle, N	EWING fa <i>iden Surn</i> en		CIURI
Be c	WALTER BURRELI										
T <sub>o</sub>				a				HULL			
	19a. Informent's Name/Reletionship (Type, Print)  19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Z										
	DARNETTA SHAVER	RS (DAUG				E AVE		BALTO.,	MD. 2	121	5
	20a. Method of Disposition	Domeyel trom State	2000	of Disposition ( tery, crematory	Name of or other pl	ace) 7/	15/9	Pate 2	20c. Location	City or	Town, State BALTO.
	1.00 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)  GARRISON FOREST VET. CEM.  OWINGS MILLS, MD. Comparison of the place of t										
	21. Signature Luneral Service Licen	see	GAKKI	22. Neme	and Add	ess of Fecil	lity	TAT .			220,110.0
	. LEW]	DS I. GW	YNN.	LEWI		. GWY	NN F	UNERAL			215-6393
	constant de	Lucyn	w	4517		RK HE	EIGHT	S AVE.	BAL	TO.	, MD.
	23a. Part1. Enter the disease, or comp shock, or heart tailure. List only	one cause	ine.	o not enter the r	node of dy	ring, such es	s cardiac o	r respiratory erre	est,	1	Approximete Intervel Between Onset end Death
	100 Cartifornia (100 and 100 a	A 1.7	1 1' D .: 1 D:								Oriset end Death
	Immediate Ceuse (Final disease or condition resulting in death)	. Athero	eroscleratic Cardiovascular Disease								
_	resulting in death)		Due to (or as	e consequence							
Examiner	_	Morbi	id Ob	esity						1	
am	Sequentially list conditions.	0,		e consequence	ot):						
	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury	Cardi	ar A.	rhyth	las I	2 <				į	
cal	Ceuse (Diseese or injury that initiated events	c. Cavori	Due to for es	e consequence		1-0					
	resulting in death) Lest		Duo to (or es t	o consequence .	J. j.						
Completed by Physician/Med		d									
cial											
ysi	Pert II. Other eignificent conditione co	ontributing to deeth b	out not resulting	in the underlyir	g ceuse g	iven in Pert	1.	23b. Did to	acco uee co	ntribute	to the cause of deeth?
F H								1 2 Ye	s 2 No	3 □ Pr	obably 4 Unknow
by										T	
ted								24a. Wes er perform		€	Were autopsy tindings eveileble prior to
ple						_			,	0	completion of cause of deeth?
E								1 ☐ Ye	s 2 No		I □ Yes 2 No
C	25. Wes gase referred to medical	/				OF Dies	of Dooth			1	
o Be	exeminer?	Hospital:		S. S. S. S. S. S. S. S. S. S. S. S. S. S	00.0	her.		(Check only one		00.4	
. To	1 ■ Yes 2 No  27. Manyer of Deeth	28e. Date of Inju			DOA 28c. Inj	4 LI N		ne 5 Reside			city)
on O	1 Natural 5 ☐ Pending	(Month, De	y Year)	. Time of Injury	W	ork?		8d. Describe ho	** injury occur	190	
cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			М		Yes 2					
Ĕ	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of in	ury - At home, c. (Specify)	farm, street, tac	tory, office		2	8f. Location (Str. City or Town,		er or Ru	rel Route Number,
Cer	1	3, 0	1-6//								
Medical Certification:	29a. Certifier 1 Certifying Phy	ysician: To the best	of my knowled	ge, death occurr	ed et the t	ime, dete e	nd plece, e	nd due to the ce	use(s) end me	enner es	steted.
ğ	(Check only 2 Medical Examone)	iner: On the basis o end manner st	t examinetion of	end/or investigat	ion, in my	opinion, dea	ath occurre	d et the time, da	te and place,	end due	to the ceuse(s)
ž	29b. Signeture end title of certifier				20o Lioor	se number		20	d. Date signe	d /Afonti	h Day Vonel

Physician /Medical **Examiner** 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effect death.

To the Funeral Director: After this certificate hes been signed by the ettending physician and completely filled in by the turnest director, page 2 should be detached for use as the burial-transit completely filled in by the turnest director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

permit. Peges 1 and 2 should be filed within a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Media

Baltimore, Maryland 2121

/Medic Examir

**Funeral** Director

or 28a-f show

238

ert II. Other eignificent conditione	contributing to deeth but not resulting in the underlying ceuse given in Pert I.	23b. Did tobacco uee con	ntribute to the ceuee of deeth
		24a. Wes en eutopsy performed?	24b. Were autopsy tindings eveileble prior to completion ot cause of deeth?
		1 □ Yes 2 No	1 ☐ Yes 2 Mo
5. Wes case referred to medical exemple?		ith (Check only one)	
. Wes case referred to medical exerginer?	26. Piece of Dea	ith (Check only one)	

	one)	201	Medical	E
20h	Signatura	and title o	f cortific	,

31. Date filed (Month, Day, Year)

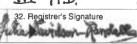
1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) end manner steted. 29c. License number 29d. Date signed (Month, Dey, Year)

les III. M.D.

D41365

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
George E. Wicks III M.D. 2600 Liberty Heights Ave. 21215

State Registrar



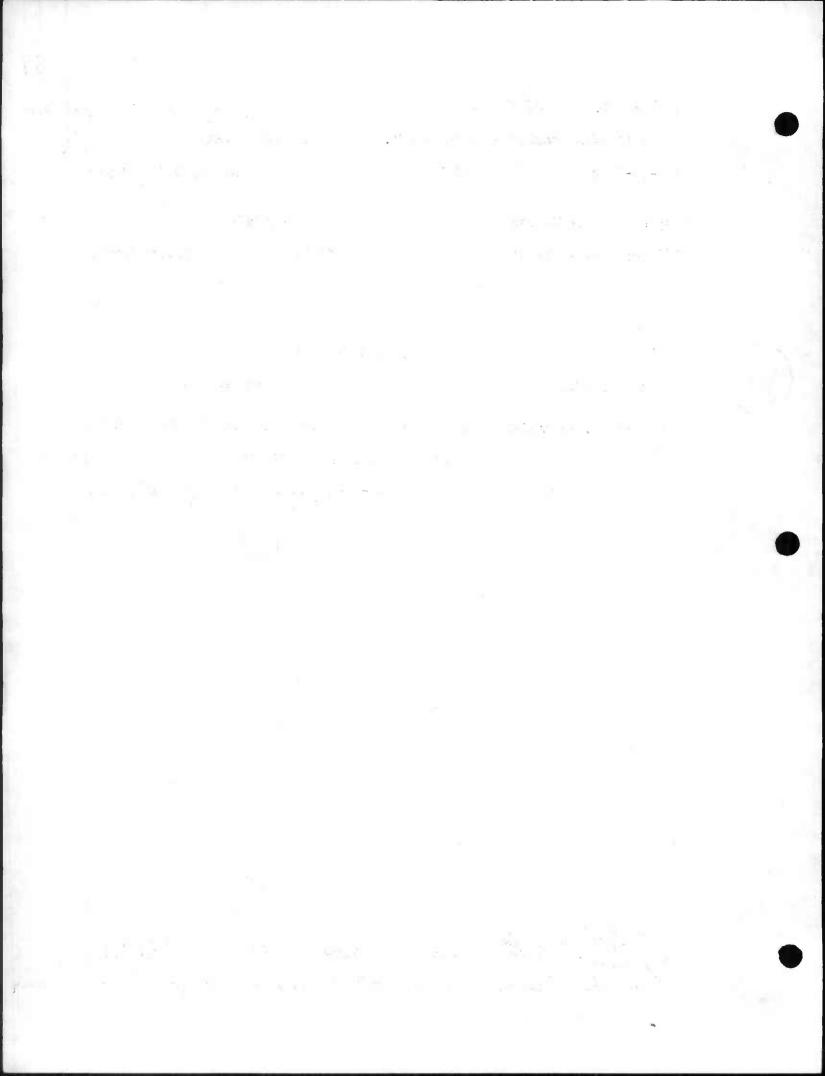
8-1

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Date of Death 3. Time of Death Dey **Physician** NNa 1997 Julu 0 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Baltimore City N/A Johns Hopkins Bayview Geriatrics Ctr. if Under 1 Year if Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 6, 1914 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕮 F Months Days New York 83 Director 216-16-5588 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show 1 ☐ Yes 2 XNo Director Dundalk Maruland Baltimore 10e. Street end Number 10f. Zip Code 10a, Citizen of Whet Country? b 21224 hams 23a 511 South 47th Street United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ੴ No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indien, Bleck, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 215-0020 natural', or 1 Yes 2 No Specify: by Specify: 3 Widowed 4 ☐ Divorced White. Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 Years Machine Operator Manufacturing 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Ethel Harris William Baisley 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Baltimore, Maryland 511 South 47th Street 21224 Katherine L. Asten/Daughter Baltimore, If Nam 20b. Place of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removel from State ö Important: I any injury o 7/12/1997 Baltimore. Maryland Oak Lawn Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 2122 21222 23a. Pert1 Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feltigre. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical immediate Cause (Finel disease or condition resulting in death) DNeumonia Examiner Examiner physician and s the buriel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) P.O. Box 68760, Physician/Medical Due to (or es e consequence of) Pert il. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, Completed by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 22 No 1 Tes 1 ☐ Yes 2 ☐ No Division of Vital director, Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 1 ☑ Naturel 2 ☐ Accident 5 Pending Investigation n 24 hours after death.

Ne Funeral Director: After the full of th 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end plece, end due to the cause(s) end manner stated. To the Hospi within 24 hou To the Funer completely fil 29a, Certifier Medical (Check only one) 29b. Signature and title of agritise 29c. License number 29d. Dete signed (Month, Dey, Year) 10052243 30. Name and edgress of person who completed cause of deeth (Item 23e) (Type, Print) Hopkins Bayview Circle 5505 Jacob Blumentha 31. Dete filed (Month, Day, Year) State 1 4 1997 Registrar



State of Maryland / Department of Health and Mental Hygiene 97 2 | 158

Physician /Medical Examiner Funeral Director	1	Decedent's Name (First, Middle, I  CYNTHIA	ast)						2. Dete of	Reg. No.			
/Medical Examiner Funeral Director	ı	CYNTHIA									Vana	3. Tir	ne of Death
Examiner Funeral Director			ANDE	RSON					JUL	Day	Yeer 1997	10	:30 AM
Funeral Director		4a. Fecility Neme (If not institution, g	ive street and number	r)				4b. City, Town, or			ty of Death	10	· JU AII
Director		MARYLAND GENER	AL HOSPITA	L			,	BALTO		N.	/A		
	0	218-60-3999	Sex 7. A 1 □ M 2 ☑ F	age (In yrs. las 48	t birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hr Hours Mir				lece (Si	ate or Foreign
£	h-	Usuat Residence of Decedent  10e. State 10b. County		10c City 7	Town or Loc	eation					- 1	Od Inci	de City Limits
notified at	5	MD N/A			LTIMOF						'		Yes 2 No
or 28a-f si be notified Director	3	10e. Street end Number		DAI	LITMUR	10f. Zip	Code			10g. Citizen o	What Cour		
_ 3 D		929 FRANKLINTOW	N RD			101. 210	0000			U.S.A		itt y r	
2 0	5	11. Marital Status	12. Was Deceden	t Ever in U.S.	13 W	Vas Dece	dent of h	Hispanic Origin? (	Specify Yes or		1 • ace - Americ	en India	n
Periodicular States	2	1 □ Never Merried 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces	? ] No	tf	Yes, spec	cify Cub	an, Mexicen, Pue	rto Rican, etc.)	Bi	eck, White,	etc.	ERICAN
t, the Medical	2	15. Decedent's	Educetion	1	16e. Decede	ent's Usu	el Occup	pation	-4-1	16b. Kind of			
he Med	2	(Specify only highest g Elementery/Secondary (0-12)	College (1-4or	5+)	life. D	O NOT u	se retire	during most of we	orking				
moC	5	12	0		NURS	SE'S	ASS"	Τ.		HOSF	PITAL		
raumatic event.		17. Father's Name (First, Middle, Las	(1)					18. Mother's Na	ime (First, Midd	dle, Maiden Surna	me)		
월	2	JAMES DOLES						MARIA	M YARBR	OUGH			
E S		19a. Informent's Neme/Relationship	(Type, Print)		19b. Mailing	g Address	(Street	t and Number or F	Rurel Route Nur	nber, City or Tow	n, State, Zip	Code)	
other traumatic		LYDIA HAWKINS (	DAUGHTER)		4313	DAN	A S	TRREET B	ALTO. M	D 21229			
or of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Removal from State		e of Dispos etery, crem	sition (Nar atory or o	ne of other pla	ice)	Dete	20c. Location	- City or To	wn, Sta	е
injury o		4 Donetico & Other (Spec		KING	S MEM	1. PA	RK	7.	77/1997	RANDAL	LSTOW	N ME	)
any injury or		21. Signature of Eunoral Secrete Lio	100 - A	M	) 22. E	STEP	BR(	OTHERS F	JNERAL	HOME P.A			
	-	28s. Part1. Enter The disease, or co shock, or Yeart failure. List onl	holications that sauss	ed the death.				AW PLACE				Anorox	rimate
cian		Immediate Ceuse (Final	,	/				•		,,		Interve Onset	imate I Between end Death
aminer		diseese or condition resulting in death)	e. MULT				H ME	ETASTASIS	S				
e line	5		CHBON	Due to (or e			_				i		
burial-transit		Sequentially list anadisians	b. CIROI	Due to (or e		-	ב						
EXa lial-tr	Š	Sequentiatly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events		240 10 (01 0.	3 0 00/13040	201100 017.							
edical	3	Cause (Disease or injury that Initiated events resulting In death) Lest	C	Due to (or es	s e consequ	ence of):	-				-		
· E		resulting in death) Lest	d		A.C						į		
d for a		Dort II. Other elemificant conditions		h		de do forma		The Police	00t D	MARKA INTERNATIONAL			July 19 a Class
detached for us		Pert II. Other eignificent conditione	contributing to death	out not resultir	ng in the uni	aeriying c	ause giv	ven in Pert I.		Id tobecco uee c			
be dete									1	Yes 2 No	3 LI Proi	MOIY	4 M OUKLOW
should										es en eutopsy rformed?	ava	aitable p	psy findings rior to n of cause
page 2									1[	☐Yes 2 <b>X</b> ☐No	10	Yes	2□ No
rector, p		25. Wes case referred to medicel						26. Plece of De					
To E		examiner? 1 ☐ Yes 2 💢 No	Hospitat:	ient 2□ER	VOutpetient	3 DC	Ott			sidence 6 🗆 O	ther (Specifi	v)	
funeral di		27. Manner of Deeth	28a. Date of Inj (Month, D		Bb. Time of		8c. Inju		T	e how Injury occ		//	
the fur		1 A Naturat 5 ☐ Pending 2 ☐ Accident investigati		ау төаг)	Injury	М		Yes 2 □ No					
in by		3 ☐ Suicide 6 ☐ Could not determine	28e. Plece of tr building, e	njury - At home etc. (Specify)	e, farm, stree	et, factory	, office		28f. Locetion City or	(Street and Num Town, State)	nber or Rura	l Route	Number,
completely filled Medical Ce		29a. Certifier tX☐ CertifyIng F (Check only one) 2 ☐ Medical Exa	hyelcian: To the best miner: On the basis of and manner s	of examination	dge, death of end/or inve	occurred estigation,	et the tir , in my c	me, dete end plec opinion, death occ	e, end due to the urred et the tim	ne cause(s) end r e, date end place	nenner es si e, end due to	eted.	ise(s)
completely filled		29b. Signeture and title of certifier				290	. Licens	se number		29d. Date sign	ed (Month,	Day, Ye	ar)
0		Jehmina	Kanara	l, M	1 .D.		892			7	17/9	7	
2	3	30. Name end eddress of person who	completed ceuse of		Sa) (Type, P	orint)	YLA	ND GE	NEPAI	HOSE	ITAL		
State	3	31. Dete filed (Month, Day, Year)		trar's Signature	0 1	-		- 010	MAIL	,,,			

DHMH 16 Rev 6/95

ten	120,240 /	-14	-97 Fillig/49 W.H.PerrDoctor		Certificate of	Death	F	leg. No.		-110.
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Armondo L. Alessar	ndri			2. Date of Dea June	th Dey	Yeer 97	3. Time of Death
	Examir Funeral Director		209-16-2520 1X M 2□F	*	est birthdey) If Under 1 Yeer Yrs. Months Deys	4b. City, Town, or Lo Fallston If Under 24 Hrs. Hours Min.		Harf Year)	ord  9. Birthpla	ace (State or Fore
ī	Maryland f ahow ed at	5	Usuel Residence of Decedent  10e. Stete 10b. County  Maryland Harford	10c. City,	Town or Location	l Air				d. Inside City Limi
	th with the P 23a or 28a-	al Director	10e. Street end Number 955 L. Hillswood Road		10f. Zip Code	014		10g. Citizen of N		y?
020	n 72 hours after deeth with the Marylan "natural", or items 23s or 28e-f show ideal Examiner must be marted at	by Funeral	11. Maritel Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 Narried  1 Never Married 2 Narried  1 Never New Year or Dates	□No	13. Wes Decedent of If Yes, specify Cuil		ecify Yes or No- Rican, etc.)	14. Rac Bled Specify	e - American ck, White, etc. White	tc.
21215-0020		Completed	15. Decedent's Education (Specify only highest grede completed)  Elementary/Secondary (0-12)  College (1-40)  College (1-40)	ır 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retine Claims Exam	ed) during most of worki	ng	16b. Kind of Bi		istry rity Adm
Maryland	should be filed withing the Mental Hyglene. merked other than imetic event, the Mental t	To Be C	17. Fether's Neme (First, Middle, Last)  LOTENZO ALESSANDTI			18. Mother's Neme Teresa	Cr	uciani		
Baltimore, Mar	permit. Peges 1 end 2 sho Department of Haalth end I Important: if Itam 27 is me any Injury or other traums once.		19a. Informent's Neme/Reletionship (Type, Print)  Anna Mae Alessandri (wif)  20e. Method of Disposition  1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stet  4 ☐ Donetton 5 ☐ Other (Specify)  21. Signature of Funanci Service Licensee	20b. Ple	19b. Meiling Address (Stree 955 L. Hill ace of Disposition (Name of metery, cremetory or other plants odlawn Cemeter 22. Name and Addr Schimunek	lswood Rd.	, Bel A Dete /2/97	ir, MD 20c. Location - Baltim	21012 City or Town	4 m, State Maryland
	Physicían /Medical Examiner	ler	23a. Part 1. Enter the disease, or complications that caus shock, or heart fellure. List only one cause on each Immediate Cause (Finel disease or condition resulting in deeth)	Car	Do not enter the mode of dy	ring, such es cardiac o	r respiretory en	est,	A	47 Approximete nterval Between Onset end Death
ox 68760,	death certificete be executed e attending physician end of for use as the buriel-transit	an/Medical Examiner	Sequentieily list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initieted events resulting In deeth) Lest		es e consequence of):  ON OFF CTLO.  es e consequence of):	g ageca		esse( )		
). Bo	b deat he att	Physician/	Pert If. Other algnificant conditione contributing to death	but not result	ting In the underlying cause g	iven in Pert I.	23b. Did to	obacco use co	ntribute to t	the cause of deat
P.0	thet the da ed by the e detached		Cardiomionathy				1 D Y	es 2 No	3 Probe	ably 4 Unkno
Vital Records,	aw requires is been sign 2 should be	Completed by	Caranoma of	the	s to mach		24a. Was e perfor	en eutopsy med?	com	e eutopsy findinge lable prior to pletion of cause seth?
	stcian: The certificate irector, pa	o Be Co	25. Wes case referred to medical exeminer?  1 2 Yes 2 No Hospital: 1 I no	od.ox.	Charles Palaned	ther:	(Check only or	10)	10	Yes 2□ No
of	Physe Brthis	-	27. Manner of Deeth 28e. Date of In	ijury 2	R/Outpatient 3 DOA 28c. Injury Wo	4 ☐ Nursing Hor	28d. Describe h	ence 8 □Oth ow Injury occur		
Division	To the Hospital or Attanding F within 24 hours aftar death. To the Funeral Director; Atter completaly filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pleca of I		M 1E	Yes 2□No	28f. Location (S City or Tow		per or Rurel I	Route Number,
	he Hospital in 24 hours he Funeral ipletaly filled	edical	29a. Certifier (Check only one)  Certifying Physician: To the bessend manner:	of examinetio	iedge, deeth occurred et the ti on end/or Investigation, in my	ime, dete end plece, e opinion, death occurre	end due to the c ed at the time, d	ause(s) end me late and plece,	enner es stet end due to t	led. he cause(s)
	To the within To the comple	Z	29b. Signature end title of cartifier  Revold	5 MM	Do	9574	2	9d. Dete signe	d (Month, De	ay, Yeer)
			30. Name and address of person who completed cause of 10 4 Plumfree Rd	deeth (item 2		014,				

State

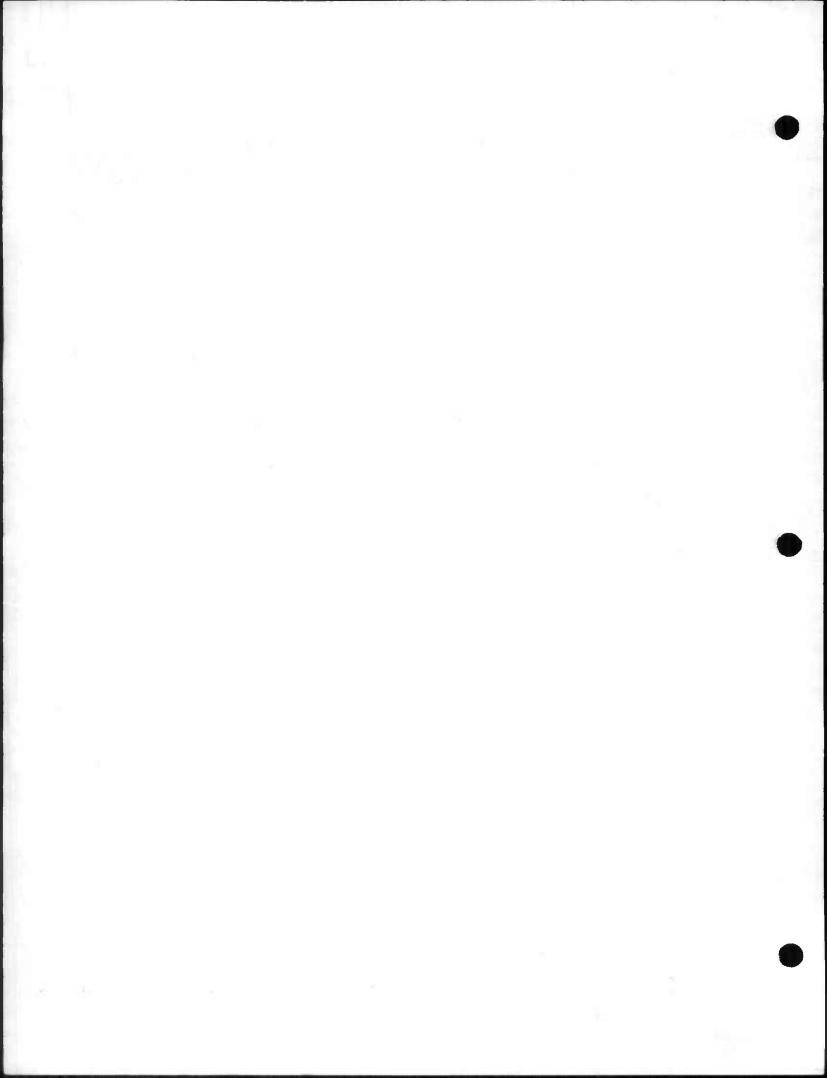
31. Dete filed (Month, Day, Year)

Penn Street, Baltimore, Maryland 21201

State Registrar David

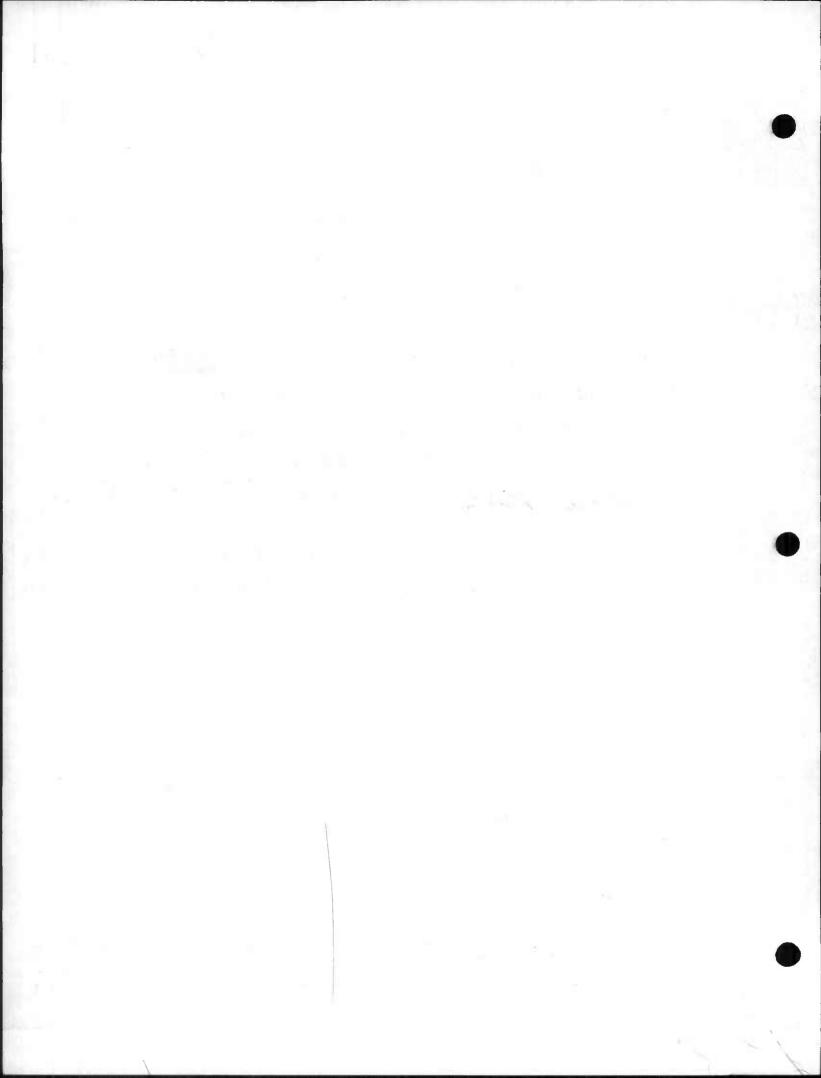
31. Data filad (Month, Day, Year)

JUL 1 4 1997



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month ROBERT BROOKS 13:48 1997 ゴンレイ 08 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Bayview Medical Center Baltimore Johns Hopkins 7. Age (In yrs. last birthday) | H Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Sociel Security Number 6. Sex 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1€MM 2□ F Yrs Director 217-05-1263 SEP 18, 1915 VA Usuel Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at Director XXYes 2 No MD N/A BALTO 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò 2803 RIGGS AVE ms 23a 21216 U.S.A. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: þ Specify: BLACK 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede comp 16b. Kind of Business/Industry completed) Elementery/Secondery (0-12) College (1-4or 5+) 12th DISPATCHER FACTORY permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygh
Important: If Item 27 is marked
any injury or other 2yrs Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be P ROBERT BROOKS SR ELLA ALLEN 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20b. Plece of Disposition (Neme of JULY 14 DONNA STEEN/DAUGHTER
20a. Method of Disposition Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) MD NATIONAL MEM PK 1997 LAUREL, MD 21. Signeture Funeral Service Licensee 22. Name end Address of Fecility BETTS FUNERLA HOME 1129 N. CAROLINE ST BALTO 21213 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Myocardial 1 day Examiner Examiner physicien end s the burief-transit or Attending Physician: The lew raquiras that the death certificata be executed Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or es e consequenca of): P.O. Box 68760, Physician/Medical Due to (or es e consequence of): Pert II. Other eignificent conditione contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown signé bed Records, þ Completed 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was en eutopsy performed? certificate has b 2 No Division of Vital director. 25. Wes cese referred to medical examiner? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpetient 2 □ ER/Outpetient 3 □ DOA this funerei 28e. Dete of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? After 5 Pending investigation 1 Maturel efter death. 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) á 4 Homicide filled a Funeral L within 24 hou To the Funer completely fil 29a. Certifier Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es steted. Medical 2 Medical Exeminer: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. To the 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) Physician RES-000 July 08, 1997 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) 4940 Eastern Avenue Johns Kaptine Bayview Hospital ELDADAH Z.A. Baltimore, Mb 21224 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State relia Davidson Registrar -Randall 1 4 1997



21162 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** 12:14 am Edna Barnes Mae 10 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Baltimore City

If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
(Month, Dey, Year)
06-27-25 4c. County of Deeth Examiner 5. Social Security Number Memorial Hospita 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F 72 Yrs. Director 217-20-3326 Md. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 7 is marked othar than "natural", or itams 23s or 28e-f show traumatic event, the Modical Examiner must be notified at 10d. Inside City Limits Md NA Baltimore 1 □Wes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21239 1202 Silver Thorne Road USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes ANO If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Š Specify: 3 ☐ Widowed 4 ☐ Divorced "naturaj', Black Completed 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Depertment of Heelth end Mental Hygiene. Important: If Itam 27 is merked other than "I any Injury or other traumette event, the Med Elementary/Secondery (0-12) College (1-4or 5+) Housewife 12th Grade in home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Wallace Sally 2 William Wallace 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 21239 1202 Silver Thorne Road Baltimore, Md. James Barnes 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State Voshell Mem. Gardens 07-14-97 Dundalk, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Baltimore, Maryland 21202 Karen m. 16oce WM.C. March FH 1101 E. North Avenue 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. **Physician** /Medical Immediate Ceuse (Final Z days SEPSIS disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner TRICUSPID REGURGITATION bunal-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): pue physician s the burial Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of) Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed by Diabetes mellitus 24a. Was en eutopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 No certificata Vital 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Deeth Medical Certification: 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred vision 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 16 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner es steted. To the Host within 24 ho To the Functional (Check or one) 2 Medical Examiner: On the besis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. and title of gentile 29b. Signatura 29c. License number 29d. Date signed (Month, Dey, Yeer) D.O. July, 10, 1997 AT 2438946 MIG 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Kenneth G. Fulp, O.O 17 Lincoln Woods Way 18 Perry Hall, MD 21128 31. Dete filed (Month, Dey, Yeer) Registrar's Signeture State

DHMH 16 Rev 6/95

Registrar

JUL 1 4 1997

Barnes

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Ite	m26 7-14	-97		.H.Per Doct	or	Maryland /	Departme Certific		Health and N Death	fental Hy	giene Reg. No.	97	2116	3	
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	/Medi			Aaron			BROV	VN		July			5:56 P	. 1	
ز	Exami	ner	4a. Facility Name	(If not institution, given	e street end numbe	r)			4b. City, Town, or Le	ocation of Deat	h 4c. Coun	ty of Death			
F	Funeral Director		France 5. Social Security		are Hospi Sex 1∰M 2□F	tal Cent Age (In yrs. last) 77	ter birthday) If Un Mont	der 1 Yea		8. Date of Bi	Balt av. Year) 20	9. Birth	more  9. Birthplace (State or Fore Country) MD.		
٠,			Usual Residenca	of Decedent											
	ehow	_	10a. State	10b. County			own or Location						10d. Inside City Lin		
	e Ma	Director	MD.	N/A		BA	LTIMORE						₩ Yes 2□	No	
	or 28	Sire	10e. Street and N	lumber			10f.	Zip Code			10g. Citizen of	Whef Cou	ntry?		
	th w	20	253	3 McHENRY	ST.		21		223		US	Α			
	dea dea	Funeral	11. Maritel Status		12. Was Deceder Armed Forces	t Ever in U,S.	13. Was De	cedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	Specify Yes or No- 14. Rece -					
21215-0020	s 1 end 2 should be filed within 72 hours efter death with the Maryland I Health end Mentel Hygiene. I Health and Mentel Hygiene. Item 27 is marked other than "natural", or tiems 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11	rried 2 Married 4 Divorced	1 Yes 2 If Yes, Give	No 11/4	2   1□ Yes	# No		Moan, etc.)	Spec	ack, White, <sup>ify:</sup> AME	RICAN		
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Mar	l 2 sho		ALVIN BROWN  BERTIE JONES  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State										Code)		
	1 end Health Brn 27		JOYCE C		(DAUGHTE	-			Y ST. BALT		21223				
Baltimore,	00		20a. Method of Di 1∰ Burial 2 4 ☐ Donation	isposition 2  □ Cremation 3  □ i 5  □ Other <i>(Speci</i> i	Removal from Stat	e came	of Disposition ( itery, crematory of RISON FO	or other pi		Date /8/97	OWINGS				
■ Balt	permit. Pag Depertment Important: It any Injury o		23a. Part1. ENer	Service Lice	aplications that cause	A death. D		300	BROTHERS EUTAW PL.	BALTO.	MD. 2	P.A. 1217	Approximate		
	Physician /Medicai		Shock, or ne	eart failure. List only	one cause on each	1	Interval Between Onset end Death								
	Examiner		Immediate Cause disease or condit resulting in death	tion	e. Athe	roscler	otic Ca	rdiov	ascular D	isease			1 year		
	D it	iner	•		h	Due to (or as	a consequence	of):							
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687	deeth certificete b e ettending physic ed for use es the b	Physician/Medical	Cause (Disease of that initieted even resulting in death)	nts	C	Due to (or as	e consequenca o	of):							
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	dee od fo	sici	Part II. Other algn	ificant conditions	ontributing to death	but not resulting	in the undertyin	g cause g	iven In Part I.	23b. Did	tobacco use c	ontribute t	o the cause of dea	ıth'	
s, P.O	es that the digned by the be detached	by Phy	Ins	sulin Depe	ndent Dia	betes M	ellitis			1 🗆	Yes 2□ No	3□ Pro	bably 4 19 Unkn	ow	
Records	requir been s should		Нур	ertension							an autopsy ormed?	av	ere eutopsy finding allable prior to empletion of cause	js	
	The law ate hes b page 2 s	Completed								10	Yes 2™No		deeth?  ☐ Yes 2☐ No		
Vital		Be (	25. Was case refe exeminer?	erred to medical					26. Place of Deat	h (Check only	one)				
of V	S 50	2		No	Hospital: 1 Inpat	tient 2 ER/0	Outpatient 3	3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)							
	Ing When		27. Menner of Dea 1 ☐ Naturel 2 ☐ Accident	ath 5 ☐ Pending investigatio	28e. Dete of In (Month, D	jury 28b	D. Time of Injury	28c. Inji W	ury at ork? □ Yes 2 □ No	28d. Describe	how injury occu	irred			
Division	or Attendition of the death.  Director: A d in by the fu	ertification:	3 Suicide 4 Homicide	6 Could not be determined	e 28e. Plece of Inbuilding, e	njury - At home, etc. (Specify)	farm, street, fac	tory, office	1	28f. Location ( City or To		ber or Run	al Route Number,		

To the Hospital or Attanding Physician: The law requires that the deeth or within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the ettend completely filled in by the funerel director, page 2 should be detached for us

Medical

114 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner as steted.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29a. Certifier (Check only one) 29b. Signatur

29c. License number 0 27315

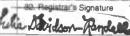
29d. Date signed (Month, Day, Year)

s of person who completed cause of death (Item 20a) (Type, Print)

Fryenborg, MD L 31. Date filed (Month, Dey, Year)

9000 Franklin Square Drive Baltimore, Maryland

State Registrar



DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Items26,27,31 7-14-97 FilmG749 W.H.PeriDoctor Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3 Time of Death **Physician** Monti Bellami Fart July 1997 /Medical 4e. Facility Name (If not institution, giva streat end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** if Under 1 Yaar If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) BALTIMORE AGNES HOSPITAL 5. Social Security Number 7. Aga (In yrs. last,birthday) Birthplece (State or Foraign
 Country) **Funeral** 150M 2□ F 244-56-44 56 Yrs. Director Usual Rasidance of Decedant the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits other traumatic event, the Medical Examiner must be notified at Baltimore 1 Yas 2 No Director Maryland 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 5 21230 Wicomico Items 23a Funeral Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 12. Wes Decedant Ever in U,S. Armed Forcas? 11. Marital Status Race - American Indian, Black, Whita, atc. 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1□ Yas 2□ No Specify: Black þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry filed within 7 Hygiene. permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Decker Salvage Cutter 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Bellamy 19b. Mailing Addrass (Street and Number or Fjural Royte Number, Sity of, Town, State, Zip Coda) 21223 Bother Bellany 2761 Fairmoung Maryland 20b. Place of Disposition (Name of cemetery, cramatory or other place)

H. Zion (cemeter) 20a. Mathod of Disposition 1 ■ Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Sarvice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batwaan Onset and Daath **Physician** /Medical Immadiata Cause (Final disaase or condition rasulting in death) Examiner Physician/Medical Examiner Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying Causa (Disease or injury that initiated avants rasulting in daath) Last Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown Be Completed by 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveitebla prior to completion of causa of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes casa rafarrad to medical axaminar? 26. Placa of Deeth (Check only ona) Hospital: 1 Yas 2 No Othar: 4 ☐ Nursing Home 5 ☑ Rasidance 6 ☐ Othar (Specify) Medical Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA 28e. Data of Injury (Month, Day Yaar) 27. Mannar of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred Natural 2 Accident 5 Pending invastigation 1 ☐ Yas 2 ☐ No Could not be datarmined To the Hospital or Atta within 24 hours efter de To the Funeral Directo completely filled in by the 3 ☐ Suicida 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Numbar or Rural Routa Numbar, City or Town, Stata) 4 Homicide 12 Cartifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner es steted. 29a. Cartifiar (Check only one) 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) and manner stetad. 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print) Caton Ave, St Agnes Hosp, Baltotto 21229 State

Registrar

AVME. N. S. S. S.

257 (2.300)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

				Certificate of L	Death	R	eg. No.	
	1471		Decedent's Name (First, Middle, Lest)	n la =0		2. Dete of Deer		3. Time of Death
	Physic		JOSEPHINE COSby	/		JULY	6, 1997	12:07PM
8	/Medi Examii		4e. Fecility Name (If not institution, give street end number)	4	lb. City, Town, or I	1	4c. County of De	
4	LAdimi	ICI	1422 MAY COURT		BALTIN		1///	7
Н	Euroval		5. Sociel Security Number 6. Sex 7. Age (In vrs. last bit	rthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 8	irthnlace (State or Foreign
1	Funeral Director		4 d	Yrs. Months Days	Hours Min.	(Month, Dey	Year)	irthplace (State or Foreign Country)  ARY (ANC)
			Usual Residence of Decedent				-30 1	THEY GING
	wo m		10a. State 10b. County 10c. City, Tow	n or Location				10d. Inside City Limits
	Mary 1 sh	0	Mr n/A Bn/	L. C. FRE				1 Yes 2 No
	the 288	Director	10e. Street and Number	TIMORE 10f. Zip Code		1	0g. Citizen of What (	Country
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	72 hours efter death with the Marylend naturel', or items 23e or 28s-f show dies Examiner must be notified at	Funeral	1111	212.			45	1+
	iter dea	E I	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces?	<ol> <li>Was Decedent of Hi If Yes, specify Cube</li> </ol>	n, Mexican, Puert	o Rican, etc.)	14. Race - An Bleck, Wh	
20	s eff	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☑ Divorced Year or Dates:	1 ☐ Yes 2 🛂 No	Specify:		Specify: 1	21-06
8	"naturel",	Q Q					1	CACK
21215-0020	s within 72 h liene. r than "natu	Completed	15. Decedent's Education 16e (Specify only highest grade completed)	. Decedent's Usuel Occupa (Give kind of work done of	turing most of wor	king	16b. Kind of Busines	s/Industry
12	within ene. than "	E E	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired	1 -		11 -	110 V -
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in c	d in o	Be	17. Fether's Neme (First, Middle, Last)	•	18. Mother's Nan	ne (First, Middle, I	Meiden Sumeme)	
yla		2	COWARD VINCENI		ELL	A 6	OINS	
Maryland	d 2 should th end Mer 7 is marke treumatic		19a. Informent's Name/Relationship (Type, Print) 313 TER 19b	. Mailing Address (Street e	end Number or Ru	rel Route Number	, City or Town, Stete,	Zip Code)
			ESSIE IIMMONS 2	745 MATT	hews	5t. B1	alto. M	d.
re	ges 1 en t of Heal If Item 2 or other		20a. Method of Disposition 20b. Plece of cemete	f Disposition (Neme of ry, cremetory or other plec	e)	Dete	20c. Location - City of	or Town, State
Baltimore,	Peges Tent of I nt: If Ite		1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)	chi=11. C=	METERY	7/11/97	BALta.	Md
Ħ	그 투원를		21. Signature of Funeral Service Licensee	22. Name and Addres	s of Fecility	0 7 8	2010	Md. 1 Baltond.
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	_		1 Willer	JEFFMIII	ler V.C	, tune	KAL HO	ME + SERVICE
			23a. Part 1. Ent. 1100 disease, or complications that caused the death. Do shock or near failure. List only one ceuse on each line.	not enter the mode of dying	g, such es cerdiac	or respiretory err	est,	Approximate Intervel Between
	Physician / /Medical		turnification of the state of t	1 +	2			Onset end Death
	Examiner		Immediate Cause (Final disease or condition resulting in deeth) a.	ve Myrer	105ler	6RZ		
		_		consequence of):	105 len			
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	end Fran	Examiner	Sequentially list conditions, if any leading to immediate	consequence of):				
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	the etter	Physician	Pert II. Other eignificent conditione contributing to death but not resulting le	n the underlying cause give	en in Pert I.	23b. Did to	bacco use contribu	te to the cause of death?
P.0	at the by the	Phy				1 🗆 Y	es 2 No 3	Probably 4 Unknown
Ś		by						
Record	.≒ o o					24a. Wes e		. Were eutopsy findings eveileble prior to
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Vital	iclen: Th certificate rector, pag		25. Wes case referred to medical	-	Of Diago of Dag			14 163 2 110
5		To Be	examiner?	trations 3 DOA Othe	ar.	th (Check only on		- 4.1
ō							ince 6 Other (Sp ow injury occurred	өспу)
on	Attending Ph or death. ector: After th by the funeral	ţ.	1 Naturei 5 ☐ Pending (Month, Dey Year)	njury Work	k? Yes 2□No			
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Division	- 4	Certification:	4 Homicide determined building, etc. (Specify)	in, eroor, ractory, omeo		City or Town		toror realization,
_	pitai ours erel filled		29a. Certifying Phyeiclan: To the best of my knowledge	de atte a common de the attention				
	Hos 24 hr Fun stely	edical	(Check of 2 Medicel Examiner: On the basis of examinetion en	d/or investigetion, in my op	oinion, deeth occu	, end due to the ce rred et the time, d	euse(s) end menner e ete end place, end di	ue to the cause(s)
	To the Hospital or Att within 24 hours effer of To the Funeral Direct completely filled in by	Mec	and menner stated.  29b. Signature and title of certifier	29c, License	number	2	9d. Date signed (Moi	oth Day Vear
	5 ¥ 5 8		and this of certified			2		
	$\bigcap$		Loudorte MY	0.0	.M.E.		JULY 7,	1991
	1/2		30. Name end eddress of person who completed cause of deeth (Item 23a)	(Type, Print)				
	1		V-LARON LUGE, MJ	111 Penn S	treet.	Baltime	ore, Mar	y1and21201
	Sta		31. Date filed (Month, Day, Year)					
	Registr	ar	JUL 1 4 1997 Julia Muridson-Rande	Se				

97-3800-510 wlc RASHAUN COLEMAN

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- 141-State of Marylan ygiene

a	/	Department	or	Health	and	mentai	H
		Certificate	of	Death	7		

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2		b	b
Tests	9	0	-

Physician
/Medical
Examiner

**Funeral** 

item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinet must be notified at

ö permit. Pege Depertment of Important: If any injury or

Baltimore, Maryland 21215-0020

Decedent's Name (First, Middle, Last) Kashaun 4e. Fecility Nema (If not institution, give street end number)

Hexandria le man

2. Dete of Deeth Month July

Reg. No.

3. Time of Death

10d. Inside City Limits

4b. City, Town, or Location of Deeth

10,1997 135p 4c. County of Deeth

2842 POTEE

Social Security Number 1 □ M 2 🖫 F 7. Age (In yrs. last birthday) Months (0 Yrs.

BALTIMORE 8. Date of Birth (Month, Dey, Yeer If Under 24 Hrs. Hours Min. If Under 1 Year Days

Birthplece (State or Foreign Country)

Director Usuel Rasidenca of Decedant Pegas 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23s or 28s-f show

Director

ð

Completed

10e. State Mo

10b. County NA

City, Town or Location Baltimore

1 Yes 2 No 10g. Citizen of Whet Country?

MZA

10e. Street end Number

SUN 11. Marital Status

12. Was Decedant Ever in U,S. Armed Forcas? 1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

STREET

21216

10f. Zip Coda

Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Race - American Indien, Black, White, etc. Specify: lac

60

15. Decedent's Education (Specify only highest grede completed) Elemantary/Secondary (0-12)

Collaga (1-4or 5+) NA

1 Yes 2 No
If Yas, Give
Year or Detes:

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) Student

1 ☐ Yes 2 ☑ No Specify:

16b. Kind of Business/Industry

17. Fethar's Name (First, Middle, Last)

Ischan-EMONTE

18. Mother's Name (First, Middle, Maiden Surname) Inda 4 Man 0

0

19a. tnforment's Neme/Ralationship (Type, Print) GOT

tunt 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State

9456 20b. Pleca of Disposition (Name of cametery, cremetory or other place) at. Mem Yark

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) lechanicsville, 20c. Location - City or Town, Stete

4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatule

of Funeral Service Licanse Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failule. List only one cause on each lina.

22. Name end Address of Facility toperal march tuneral

Hong-u 21212 Approximata Interval Between Onset end Death

aurel

Physician /Medical Immediete Ceuse (Final disease or condition resulting in death) Examiner

Examiner

Physician/Medical

by

Completed

2

Certification:

edical

the bunal-transit

ed by the attanding physician datached for usa as the buna

signed by the

pege 2 should

director, Be

certificate hes

After this in by tha funerel

Director:

within 24 hours aftar of To the Funeral Direct complataly filled in by

P P

daeth.

end

certificate be axecuted

Records, P.O. Box 68760.

Division of Vital Hospitai or Attending Physiclan: Sequentially list conditions, if eny, leeding to immediate cause. Enter Undarlying Causa (Disaase or injury thet initieted events resulting in deeth) Last

Due to (or as e consequenca of):

Due to (or es a consequence of):

1 Yes

23b. Did tobecco use contribute to the ceuse of death? 3 Probably 4 Unknown

26. Place of Deeth (Check only one)

24e. Was en eutopsy performed?

24b. Were eutopsy findings eveilebla prior to completion of cause of daeth? Yes 2 No

25. Wes case raferred to medical MYes 2□ No

27. Menner of Death

1 Naturel

2 Accident

3 Suicide

4 Iomicide

28e. Dete of Injury (Month, Day Year) 10-97

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Tima of

28c. Injury et Work? 1 Tyes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d, Describe how injury occurred cci

28a. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) Hom

28f. Location (Stra 10 101 1 Certifying Physicien: To the best of my knowledga, daath occurred et the time, dete end placa, and dua to tha cause(s) end mennar es statad.

\*\*Medical Examiner: On the basis of exeminetion end/or invastigation, in my opinion, deeth occurred at tha tima, data and placa, end due to the causa(s) and manner steted.

2 No

29a. Certifier 29b. Sigg

re and title of certifier

5 Pending Investigation

6 Could not be determined

29c. License number O.C.M.E. 29d. Date signed (Month, Dev. Year) July 11, 1997

and Number or Rurel Routa Number

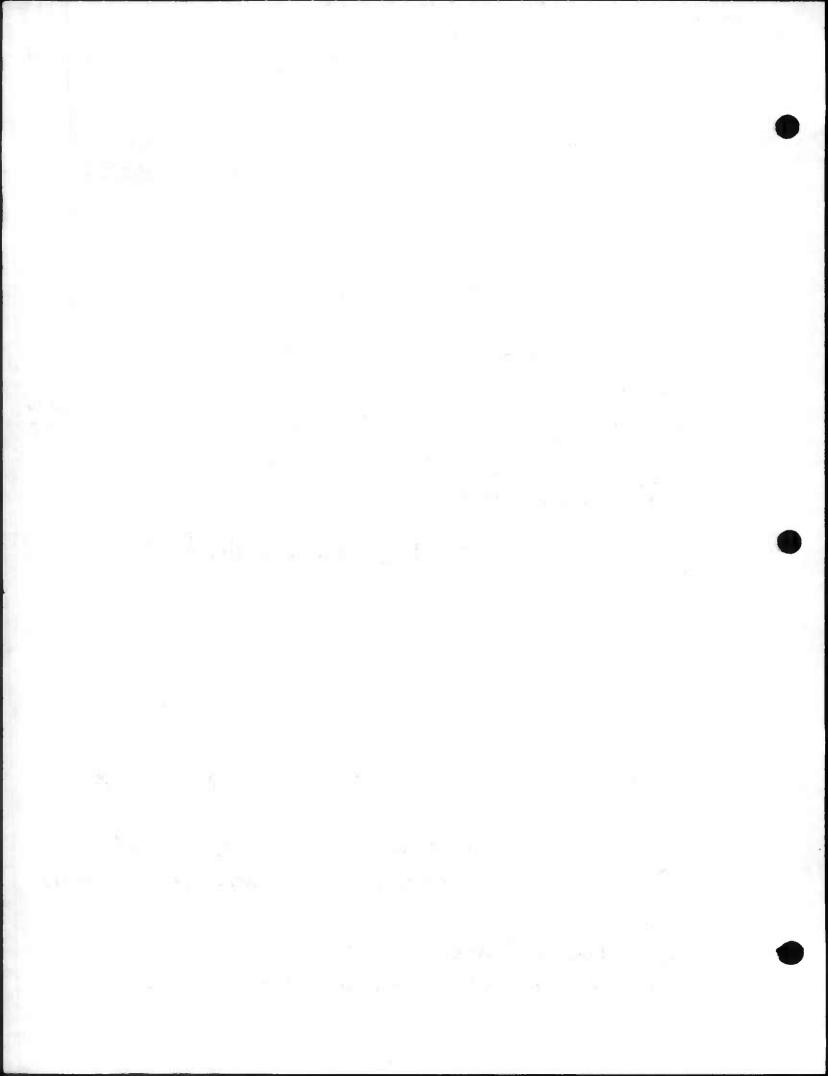
end eddrass of person who completed cause of deeth (Item 23e) (Type, Print) LOCKE

LAKEN 31. Dete filed (Month, Day, Year) 1 4 1997

111 32. Registrar's Signeture 111 Penn Street, Baltimore, Maryland 21201 Dauldson

State Registrar

**DHMH 16 Rev 6/95** 



WRC 97-3796-510 TSCHANTRE L.

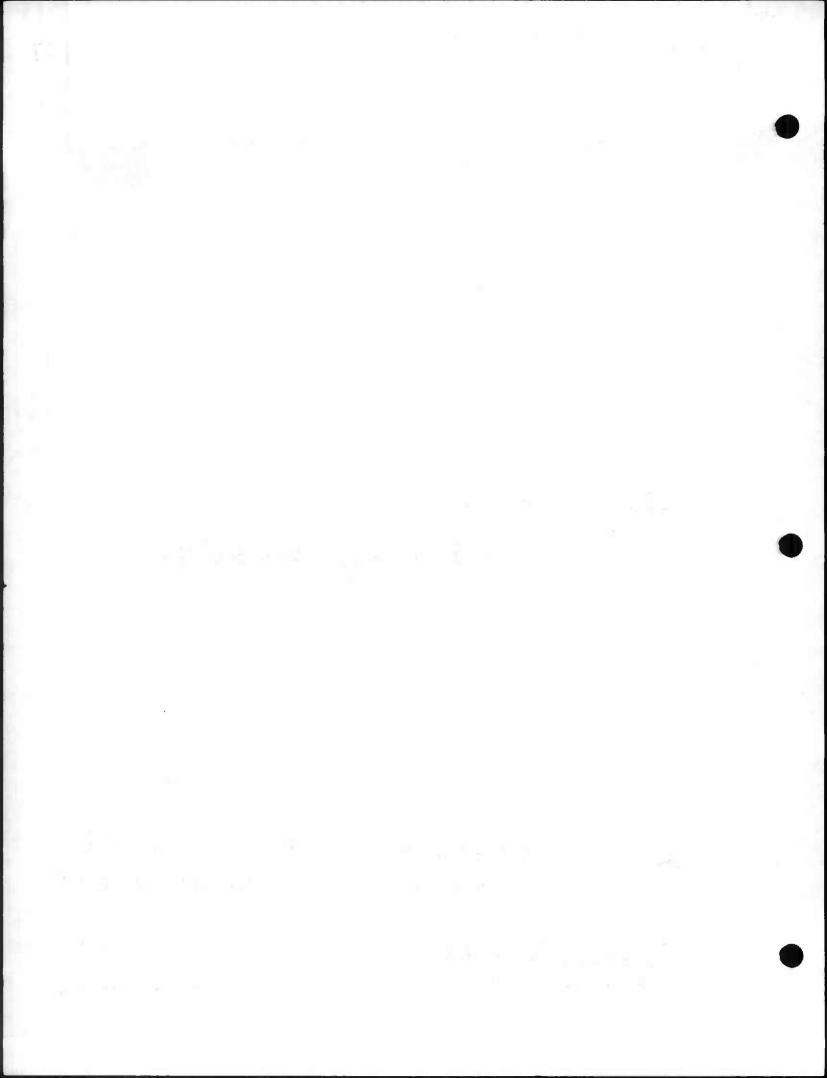
#### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

C	OLEMAN				Certificate o	f Death	Re	g. No.	
ľ	Physici	an	1. Decedent's Name (First, Middle, Las	" H . 1	C-1 - 0.0		2. Deta of Deeth Month	Day Yeer	3. Time of Deeth
	/Medi		ISCHANTRE	LE 110NTE	COLEMAN			10, 1997	1:35 PM
	Examir	ner	4a. Fecility Neme (If not institution, give			4b. City, Town, or L		4c. County of Deeth	
_			2842 POTEE ST 5. Social Security Number 6. S.		ast hirthday) If Under 1 Yea	BALTI ar   If Under 24 Hrs.		NA	
	Funeral Director			ax 7. Aga (In yrs. le	Yrs. Months Dey		8. Dete of Birth Month, Day	Year) 58 9. Birth	place (State or Foreign ntry)
	wo!		10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
	Ba-f sh	Director	Md NA	Bo	iltimore				1 Nas 2 No
	ath with the 23a or 24	ral Dire	10e. Street end Number 2842 POTEE	Street	10f. Zip Code	225	10	United S	States
020	72 hours effer death with the Meryland "natural", or Items 23a or 28a-f show adical Examiner must be notilised at	by Funeral	11. Marital Status  1 Nevar Marriad 2 Married  3 Widowed 4 Divorced	12. Was Decedent Evar in U,S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dales:	13. Wes Decedent of If Yes, specify Cu	Hispenic Origin? (Spuben, Mexican, Puerto o Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ameri Bleck, White Specify:	
5-0	72 ho	etec	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16e. Decedent's Usual Occ (Give kind of work don	upetion	cino 1	6b. Kind of Business/Ir	ndustry
121215-0020	jene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Carpen	red)		abine	-Shop
Maryland	ould be fil Mental H arked ott	Be	17. Fethar's Name (First, Middla, Lest)	1 1	•	18. Mother's Nam	e (First, Middle, M		•
Z	should bind Mente	2	19e. Informant's Name/Relationship (7	Jeman	40, 11, 12, 14, 10,	Mar	7000	12EC	
Ma	0 0 0 0	Ş	Gail ARRIVATOR	- Sister	19b. Meiling Address (Stre	1/1 0	0 0 1	11.	23116
ē,	of Health item 27 i		20a. Method of Disposition	20b. Ple	M456 Kutting	0	Date 20	Oc. Location - City or T	owh, State
9	Peges nent of I int: if ite		1 ☐ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemovel from State	metery, cremetory or other p	19	7-12.97	Ralda	HD
Baltimore,	그는원증		21. Signature of Funeral Service Licen	1110	22. Nama and Add		111-0	colored.	144
ă	Depa Impor		Aller R	Thomas:	march	FUNER	-1 +10 IN	A Wast	1-0 21215
			23a. Part1. Enter me disease, or comp shock, or heat l'ailure. List only d	lications that cousad tha death.		Ving, such as cardiac	or respiratory erres	st.	Approximele
	Physician /Medical Examiner		Immediate Ceuse (Finel disease or condition resulting in death)	. Conto	Shaffi		of l	fead	Intervel Batween Onset end Deeth
	D E	Examiner		h	•				
	eath certificete be executed ettending physicien end I for use es the bunel-trensit	xam	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	Due to (or	es e consequence of):	E			
60,	be ex		Cause (Disease or injury	c					
68760,	physi the	edical	thet initieted events rasulting in death) Lest	Due to (or	es e consequence of):				
×	ding	Σ		d					
Bo	es that the death co igned by the ettend be deteched for us	Physician/						i	
P.O.	the de	ysi	Pert II. Other significant conditions co	ntributing to death but not resul	ting in the underlying cause of	given in Pert I.		acco use contribute t	
	that the	by Pt					1 To	8 20 No 3□ Pro	bably 4 Unknown
Vital Records,	requir been s should	Completed b					24a. Wes en performe	ed? ev	fere eutopsy findings veilable prior to emplation of cause
æ	The law ete has b pege 2 s	E O					1 ☐ Yes	M	deelh?  ☐ Yes 2☐ No
ta		a)	25. Wes case referred to medical			26 Place of Deal	th (Check only one	/	
<u>&gt;</u>	\$ 00	To B	exeminer? ↑▼ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpetient 3 DOA	Other: 4 Nursing Ho			(v)
n of	ig Ph ter th neral		27. Menner of Death 1 □ Neturel 5 □ Pending	28e. Dete of Injury (Month, Day Year)	28b. Time of 28c. Injury W		28d. Describe how		00
0	Attending or death. octor: After by the fune	atlc	2 ☐ Accident investigation	1-10-11		□ Yes 2 No	Sulyrece	1 84012 E	elf.
Division	or Att	Certification:	3 Suicida 6 ☐ Could not be determined	28e. Plece of Injury - Al hon building, etc. (Specify)	ne, farm, street, factory, office	е	281. Location (Stree City or Town)	eet end Numbar or Run State)	al Route Number,
Ω	rai D			AT HO	une		2845 Ro	teest, a	71215
	To the Hospital or Attending Phwitin 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exem	sicien: To the best of my know iner: On the bests of examinetic end manner stated.	fedge, death occurred et the on end/or investigelion, in my	time, dete end plece, opinion, deeth occur	end due to the ceu red et the time, dat	use(s) end menner es s te end place, end due t	steted. o the ceuse(s)
	o the	Me	29b. Signature and title of certifier	end manner stated.	29c. Licei	nse numbar	290	d. Data signad (Month,	Day, Year)
	トメドッ		¥ / n.	6. 0. D.K.	`	D.C.M.E.		JLY 11,	1997
	71		30. Name and address of person who c	ompleted cause of death (Item :					
_	4		JUARON LOCK	C MO	.11 Penn Sti	reet, Bai	ltimore	, Marylan	d 21201

State Registrar

31. Dete filed (Month, Day, Year) JUL 1 4 1997

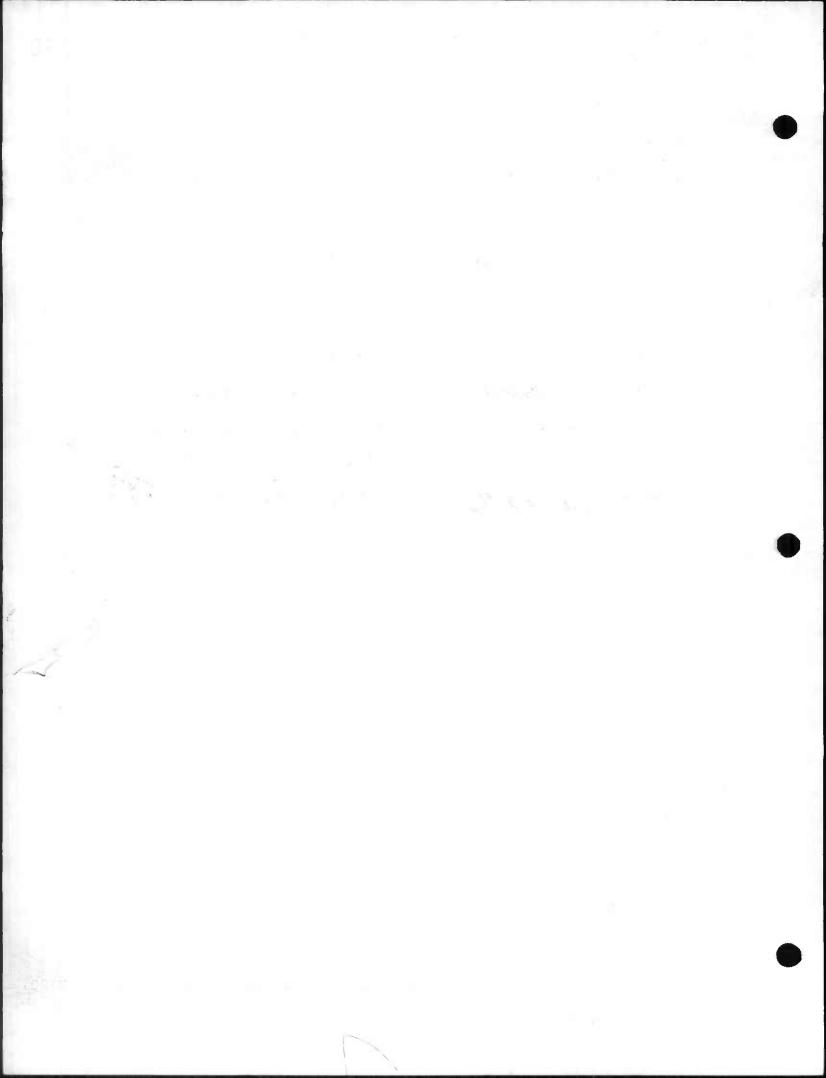


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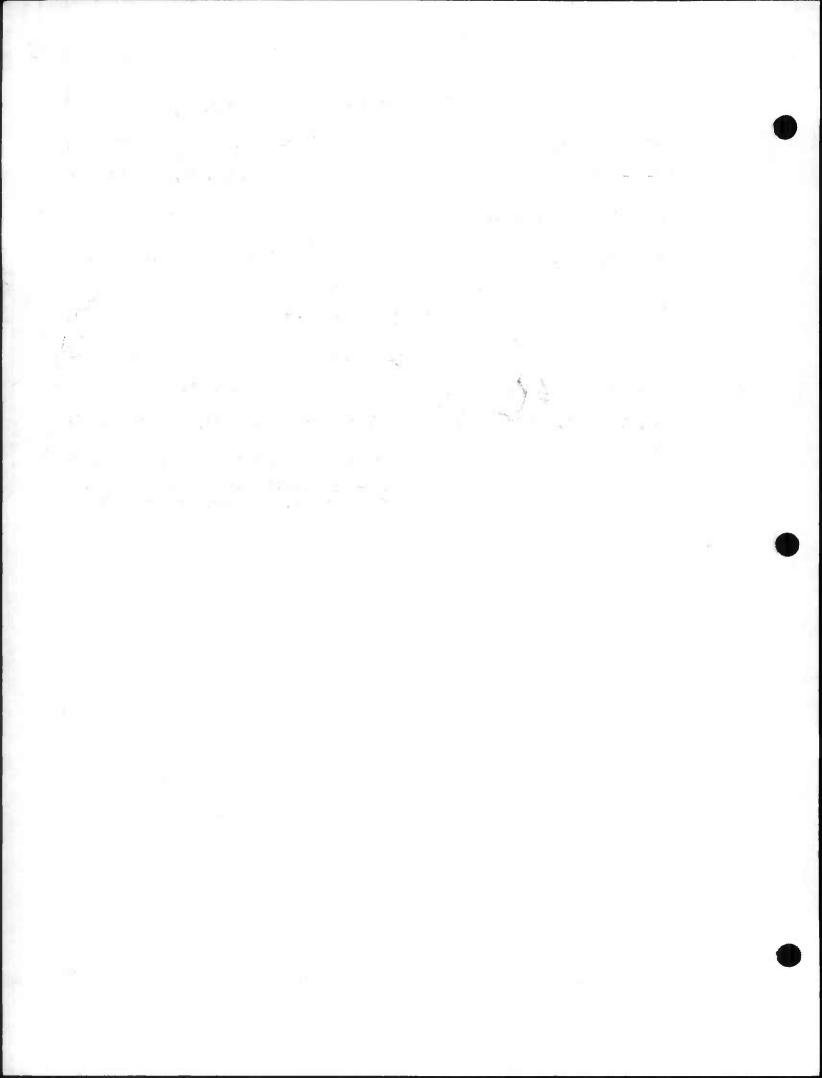
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	JUANI CALLO	TA WA	y Items: 23a part I,27  1. Decedent's Neme (First, Middle, La	per MEO G-749 7/3		dealth and Mental I	Reg. No.	2 Time of Death
	Physici /Medi	cal	JUANITA CALI	LOWAY		2. Date of Month  JULY	Dey 8 1	3. Time of Deeth 997 6:46P.1
	Examir	ner	4e. Fecility Name (If not institution, given UNION MEMORIAL			4b. City, Town, or Location of D BALTIMORE	eeth 4c. County	
	Funeral Director		215-92-3080	Sex 7. Age (In yrs. 1 ☐ M 2 ☐ F 2 4	last birthday) If Under 1 Year Months Deys		Birth Dey, Year) 1, 1973	Birthplece (State or Foreig Country)  MD
	with the Maryland a or 28a-f show be notified at	or	Usual Residence of Decedent  10a. Stete 10b. County  MD	10c. C#	ty, Town or Locetion			10d. tnside City Limit
Maryland 21215-0020	be filed within 72 has enur death water Hydisine. Id other than Carelly of Nervy 23e event, the Modif LEXINING TRUST.	To Be Completed by Funeral Director	10e. Street end Number  501 E. PRESTO  11. Manitel Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gra  Elementery/Secondary (0-12)  12th  17. Father's Neme (First, Middle, Last  NATHANIEL CA  19a. Informant's Name/Relationship (	12. Was Decedent Ever in U Armed Forces? 1   Yes 2   Yes   If Yes, Give   Yeer or Detes:  ducation College (1-4or 5+) N/A	If Yes, specify Cub  1 □ Yes 2 □ Yoo  16e. Decedent's Usuel Occup (Give kind of work done life. DO NOT use retire  WAITRESS	dispanic Origin? (Specify Yes or an, Mexican, Puerto Rican, etc.) Specify:	Specify  16b. Kind of Bi  REST  Idle, Meiden Sumen	a - American Indian, ok, White, etc.  BLACK usiness/Industry  PAURANT
Baltimore, Ma	permit. Pages 1 and 2 abould Department of Health and Ma- important: If Item 27 is marks any injury or other traumatic once.		JANNIE CAOLLO  20a. Method of Disposition  1 Buriel 2 Commetton 3 D  4 Donettion 5 Other (Special  21. Signature of Faheral Service Lice	PWAY  Removel from State  MT	1419 ENSO! Place of Disposition (Neme of temetery, cremetory or other ple  ZION CEM  22. Name and Addres	R ST BALTO,	MD 2120 20c. Location BALTO,	D 2 City or Town, State MD
100	Physician /Medical Examiner	ler	23a. Pert1. Enter the disease, or com shock, or heart tailure. List only Immediate Ceuse (Final disease or condition resulting in death)	a. MYOCARDITI		ng, such es cardiac or respiretor	y errest,	Approximete tritervel Between Onset end Deeth
Box 68760,	n certificate be executed anding physicien end use es the buriel-transit	n/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest	C. —	or es e consequenca of):			
s, P.O. B	requires thet the death certifi seen signed by the ettending hould be deteched for use es	by Physician/M	Pert II. Other significant conditions of	contributing to death but not res	ulting in the underlying cause given		Did tobecco use co	ntribute to the cause of death
Records	98 E	Completed t					Ves en eutopsy erformed?	24b. Were eutopsy findings eveileble prior to completion of cause of deeth?
of Vital R	sician: certifica irector,	Be	25. Was case referred to medical exeminer?  ★CTVes 2□ No	Hospital:	Ott	26. Place of Deeth (Check or		1 ☐ Yes 2 ☐ No
Division of	or Attending Ph siter death. Diractor: After th in by the funeral	al Certification: To	27. Menner of Deeth  1)(1)(Natural 5   Pending investigation 3   Suicide 4   Homicide   Pending investigation determined	28e. Dete of trijury (Month, Dey Year)  28e. Pleca of Injury - At he building, etc. (Specification of the second o	28b. Time of injury M 28c. Injury Wo	y et 28d. Describer 28d. Describer 28d. Location City or	be how Injury occur on (Street end Numb Town, Stete)	red er or Rurel Route Number,
	To the Hospital within 24 hours of To the Funeral I completely filled	Medical		niner: On the basis of examina and manner stated.	tion end/or investigetion, in my c	pinlon, death occurred et the tir	ne, date end place,	end due to the ceuse(s)  d (Month, Dey, Year)

State Registrar



					C	Certificate of	Death	Re	eg. No.							
	Physici /Medi		Decedent's Name (First, Middle, Las		iam Taft	Carson		2. Dete of Deet Month July 1	h Dey	3. Tim f 7 3:1						
	Examir		4e. Fecility Neme (If not institution, give	street end number)			4b. City, Town, or Lo	ocation of Deeth	4c. County							
			4913 Forge Road				Perry Ha			timore						
	Funeral Director		213-07-9198	TM OFF	(In yrs. last birtho	Months Devs		8. Dete of Birth Month, Dey, Sept. 1	Year)	9. Birthplece (Stete or Country) Maryland	Foreign					
	P # 10		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City	y Limits					
	safter douth with the Marylar or items 23s or 28s-f show sminer must be notified at	Director		ultimore		Los Trons		Perry		1 ☐ Yes	XXNo					
	with with the n	P.	10e. Street end Number			10f. Zip Code	2112		Og. Citizen of V United							
	South mus	era	4913 Forge Road  11. Marital Status	12. Was Decedent Ev	ver in U.S.	13. Wes Decedent of				- American Indian,						
215-0020	hours after death with the Manyland unal, or flame 23s or 28a-f show al Examiner must be notified at	by Funeral	1 Never Married 2 Married 3  Widowed 4 □ Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		13. Wes Decedent of If Yes, specify Cul 1 ☐ Yes 2 ☑ No		Rican, etc.)		k, White, etc.						
5-0	72 hours natural', dical Ex	Completed	15. Decedent's Ed (Specify only highest great	ucetion de completed)	16e. D	ecedent's Usual Occu	petion during most of work	ina	16b. Kind of Bu	siness/Industry						
121	Pan Pan Pan Pan Pan Pan Pan Pan Pan Pan	ald m	Elementery/Secondery (0-12)	College (1-4or 5+	)	live kind of work done fe. DO NOT use retin	ed)	9								
2			8 Years 17. Father's Name (First, Middle, Last)		<i>D.</i>	ie Setter	18. Mother's Name	o /First Adjusted A		el Industry						
E	de l	Be	George Washingto	on Cathon			10. MOUTHER STRAIN	Mary S		9/						
(E)		2	19a. Informent's Name/Relationship (7		1 ton 196. N	failing Address (Stree	t end Number or Run			State Zin Code)						
Z			Mrs. Sharon E. U			13 Forge R										
ore,	12 Tar		20e. Method of Disposition		20b. Place of D	isposition (Neme of cremetory or other ple	ece)	Date	20c. Location -	City or Town, Stete						
Ĕ	Page nent c ant: If ury or		1 Burial 2 Cremation 3 ☐ 4 Donetion 5 ☐ Other (Specify													
Baltimore	permit. Pi Departmer Important any injury 2003		21. Signeture of Funeral Service Licensee  Schnylber (Specify)  Oak Lawn Cemetery 7/14/1997  Baltimore, M  22. Name end Address of Fecility  Duda-Ruck Funeral Home of Dundalk, Inc.  7922 Wise Ave. Dundalk, Maryland 21222													
	,		23a. Parl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdlec or respiretory errest, shock or heart felibre. List only one cause on each line.  Approximate Intervel Between													
	Physician									Onset end D	eeth					
	/Medical Examiner	ш	Immediate Cause (Final disease or condition resulting in deeth)	· Colon	Con	er wit	h liver	neto	istase.	5						
	<u> </u>	_	resulting in deetin)		ue to (or es e cor					i j						
	red nsit	nin		b		9										
Ć,	execu n and iel-tra	Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that battered as the conditions of the condition	D	ue to (or as e cor	rsequence of):										
68760,	ysicia ysicia		med millered events	c	ue to (or es e con	sequence of):										
89 xc	requires that the death certificate be executed een signed by the ettending physician and hould be deteched for use as the buniel-transit	<b>Medical</b>	resulting in deeth) Lest	d												
Bo.	that the death ce hed by the ettendi deteched for use	Physician/	Pert II. Other significent conditions co	ntributing to death but	not requiting in th	- undothing source of	iven in Port I	22h Did to	bassa use sa	ntribute to the cause of	f doeth?					
P.0	t the c by the teche	hys	Total of a symmostic conditions of	initibuling to death but	not resulting in ti	ie undertying ceuse g	IVON IN FOIL I.		s 2 No		Ínknown					
S, F	es that igned be det	by F														
Records,	aw ls b	Completed						24a. Wes en		24b. Were eutopsy fir eveilable prior to completion of ca of death?	)					
	The law ate has b page 2 s	E O						1 □ Y€	s 20 No	1 ☐ Yes 2 ☐ N	No					
		Be (	25. Wes case referred to medical examiner?				26. Plece of Deatl	h (Check only on	e)							
of Vital	S 0 0	ဥ	1 ☐ Yes 2D No	Hospital: 1   Inpatient		etient 3 DOA	her: 4 Nursing Ho	me 5 Reside	nce 6 Oth	er (Specify)						
n o	or Attending Ph ofter deeth. Director: After thi In by the funeral	on:	27. Manner of Deeth 1 Natural 5 □ Pending	28a. Date of Injury (Month, Dey	Year) 28b. Tim Inju	ry Wo		28d. Describe ho	w injury occur	red						
Sio	Attending or deeth.	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	On Division	4.1		Yes 2 No	204								
Division	or Attending I efter deeth. Director: After I in by the funer	Certification:	4 ☐ Homicide determined	building, etc.	y - At home, farm (Specify)	, street, fectory, office		City or Town	reet end Numb , State)	er or Rural Route Numb	er,					
	To the Hospital or within 24 hours efter To the Funeral Director completely filled in	edical C	29a. Certifier (Check only one)  2   Medical Examone)	sician: To the best of Iner: On the basis of e	xaminetion end/o	eath occurred et the t r investigetion, in my	ime, date end plece, opinion, death occurr	end due to the ce ed et the time, da	euse(s) end me ate end place,	nner es steted. end due to the ceuse(s)						
	o the o the o the	end menner steted.  29c. License number 29d. Date signed (Month, Dey.)														
	⊢≯⊢ŏ		1/4 41 41 18	Maria	11 m U				- 1	11/97						
			30. Name end eddress of person who c	ompleted cause of dea	ath (Item 23e) (Ty	pe, Print)	NG. 210	т								
	V		3004 Emmo	rton Road	d Ab	insdon, 1	W. Q. 210	09	WILLIAM	Thomas,MD						
	Sta Registr		31. Dete filed (Month, Dey, Yeer) <b>JUL 1 4 1997</b>	gistra di	s Signature	ndalle.										



## Please Type or Print in Diack Indelible Ink. Assure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene 97

State of Maryland / Department of Health and Mental Hygiene

					y tartar b	Certifica			wichtai i i	Reg. No.	, , ,	. 1170
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Less Ohn 4a. Facility Name (If not institution, give	Cunn street and number)	,		4	b. City, Town, or		Day 29 /		3. Time of Death 2:09 A1
	Funeral Director		## Harbar Hasp for Fa 5. Social Security Number 6. Se 214-18-48 1	Centra 3 PM 20 F	In yrs. last birti	NOUCR nday) If Und Month	ler 1 Year	If Under 24 Hrs Hours Min.	Month, D	N/A ay, Year) Ry 27, 191	9. Birthplac	ce (Stete or Foreign
	Maryland a-f show iffed at	otor	10a. State 10b. County N/A	10	Oc. City, Town	or Location					100	I. Inside City Limits
	death with the Maryla me 23e or 28e-f shor Linust be notified at	Funeral Director	10e. Street and Number 3010 ASCENSION ST 11. Marital Status	12. Was Dacedent Eve	er in U,S.		Cip Code 21225 Redent of Hi	spanlc Origin? (S n, Mexican, Puer	Specify Yes or N	U.S.A	e - American	Indian,
0020	Nours after Louis, or its	d by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1.00	1 🗆 Yes	2 💢 No	Specify:	to Ricen, etc.)	Specify	AFR. F	MERICAN
21215-0020	H	Comple	15. Decedent's Edi (Specify only highest gred Elementary/Secondary (0-12)	College (1-4or 5+)		Decedent's Us (Give kind of NOT) life. DO NOT	vork done d use retired,	uring most of wo	rking	FREIG	HT CO.	100
ryland	d Menta Hy trankod oth matic event	To Be	17. Father's Name (First, Middle, Lest) BENSON CUNNINGHAM	Dieth	401		(0)	FARAH	GILMORE	, Maiden Sumen		
re, Ma	1 and 2 si 1 Health and 10m 27 is r other traur		19a. Informant's Name/Relationship (T) FRANCES CUNNINGHA 20a. Method of Disposition	M (WIFE)		10 ASC	NSION	ST. BA		21225 20c. Location -		
altimore	permit. Pages Department of mportant: if Its iny injury or o		1 Burial 2 Cremation 3 F 4 Donation 5 F Service Licens	nemoval from State	GARRIS	FORE	ST V.	A. CEM.		OWINGS	MILL M	ID
80	Dep Dep Imp any		23a. Part / Enter the divease, or combi shock, or heart jointre. List only o	ications that cause of the	death. po n	1300	EUTAW	HERS FU I PLACE g, such as cerdia	BALTO. N	1D 21217	A	oproximate
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth)	. Hy	DO XA	eme	1				C	onset and Death
Box 68760,	eath certificate be executed ettending physician end for use es the buriel-trensit	an/Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	frel.	e to (or as a co	non		efon Eggel blest	fens Tari	ein ein	reer De	re Ce
P.O.	0 0	Physician/N	Part II. Other algnificant conditions con	ntributing to death but n	ot resulting in	the underlying	cause give	on in Part I.		tobecco use co		he cause of death? bly 4 Unknown
Records,	e law requires hes been sign je 2 should be	Completed by							24a. Was	s an eutopsy ormed?	evaila	e autopsy tindings able prior to oletion of cause ath?
		0	25. Was cese referred to medical					26. Place of De	ath (Check only	Yes 2 No	101	res 22 No
of Vital	5 000	To B	examiner?	lospital: 1 Inpatient	2 ER/Out	patient 3 I	OOA Othe	r.		idence 6 □Oth	er (Specify)	
Division o	ing After fune	Certification:	27. Manner of Death  1 Anatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Dey Ye		ury M		at ? ∕es 2 □ No		how injury occur		
Div	To the Hospital or Attend within 24 hours efter deetr To the Funeral Director: . completely filled in by the i	- r	4 Homicide determined  29e. Certifier 118 Certifying Physics	28e. Place of Injury building, etc. (S	Specify)			e date and place	City or To	(Street end Numb wn, Stete)		
	the Hos hin 24 h the Fur mpletely	edical	(Check only 2 Medical Exami	ner: On the basis of exa end manner stated	amination end	or investigation	on, in my op	inion, deeth occu	irred at the time,	date and place,	and due to th	e cause(s)
	To the Comple	Σ	29b. Signature and title of certifier	hofil	35	2	9c. License	number	26	29d. Date signer	(Month, Da	y, Year)
	//		30. Name and address of person who co	mpleted cause of death	(Itam 23a) (T	ype, Print)	RA	T. N	102/	21	1	
	Sta Registr	_	31. Date filed (Month, Dey, Year)	32. Registrar's	Signature Panda M	· )	>/0	1000	0 10	- 4		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Deeth **Physician** Month Year Chesney Daniel Julu 10, 14:51 1997 /Medical 4a. Fecility Name (If not institution, giva streat and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE THE JOHNS HOPKINS HOSPITAL CITY City If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. Sept. 11, 5. Social Security Number 6. Sex 1 M 2 F 9. Birthplace (Stata or Foraign 7. Age (In yrs. last birthday) **Funeral** Maryland 40 Yrs. 216-66-8651 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director Maryland Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1440 N. Main Street 21074 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ñ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Baltimore County College (1-4or 5+) Elementery/Secondary (0-12) Police Dept. Sergeant permit. Pages 1 and 2 should be tilt Department of Health and Mental Hy Important: If Nem 27 is marked other any Injury or other traumatic event 17. Father's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Be Bobby Ray Chesney, Sr. Alice Marion McConnaughy 19e. Intorment's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Route Numbar, City or Town, Stata, Zip Code) Darryl J. Chesney - brother 2008 Hanover Pike, Hampstead, Md. 21074 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gardens July 14, 1997 Timonium, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, Md. 21102 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Betwe Onset end Death **Physician** /Medical Immediate Cause (Final · multisystem organ toulure disease or condition resulting in death) Examiner Due to (or as e consequence of) Physician/Medical Examiner 16 hrs heart failure after cardiac transplantation attanding physicien and for use es the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown signed b ρ Completed 24b. Were eutopsy tindings available prior to 24a. Was an autopsy performed? completion of ceuse of death? pege 2 s this certificeta To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifice completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28e. Date of Injury (Month, Day Yaar) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Straet and Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 \ Homicide Descritifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) and menner es steted.

2 Medicel Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Surgery 10,1997 Resident RES-000 Elaine Tseng 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Blalock 618 600 N. Wolfe St. Baltimore MD 21387 Johns Hopkins Hospital 31. Date tiled (Month, Day, Yaar) 32 Begistrar's Signature State

Registrar

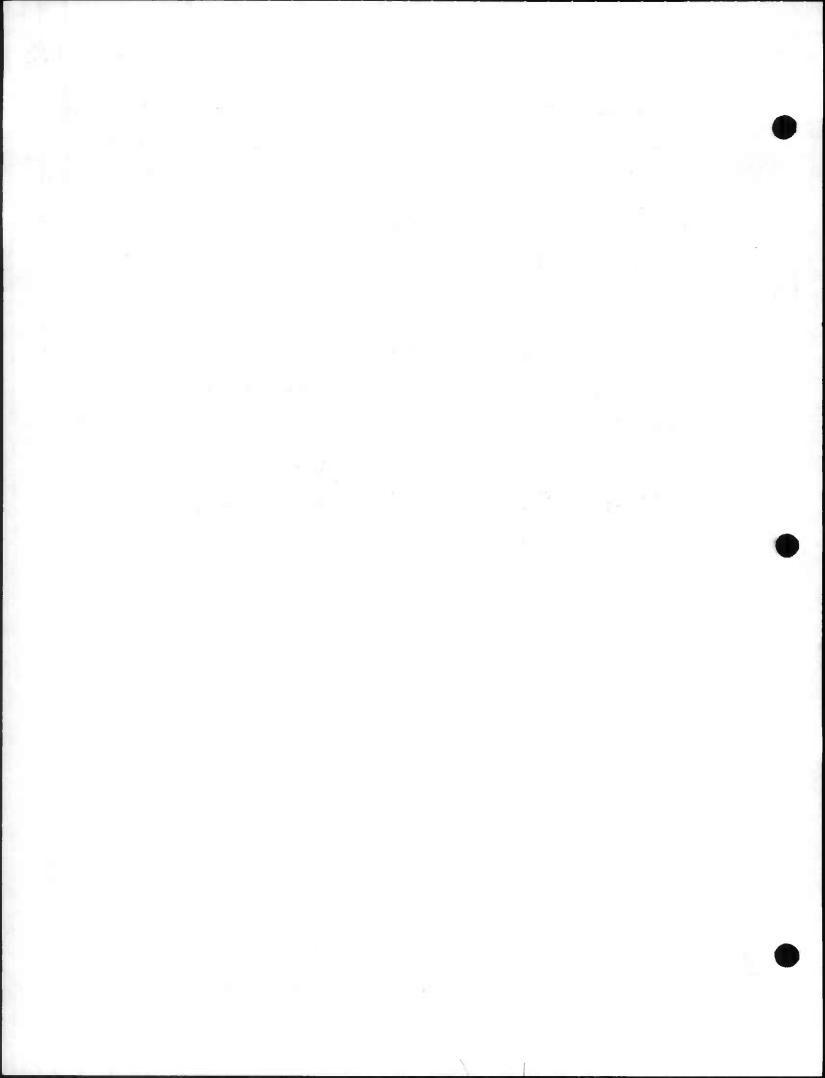
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State of Maryland / Department of Health and Mental Hygiene

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	Physic /Medi		Mary Ellis De	enny						July	9	, 19		1:1	5 A.M.
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	Funeral Director			Sex 1 □ M 270 F	7. Age (In yi	s. lest birth Yı	N	f Under 1 Ye lonths Day		Hrs. 8. Date of (Month, Sept.	Birth Dey, Ye	1926	9. Birthp Coun Mas	iece (State try) sacht	e or Foreign 1Setts
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	th the Maryland or 28a-1 show e.notified.et	Ď	Maryland Baltin	nore		Balti	imor	0							es 2 No
	r 28a	Funeral Director	10e. Street end Number	HOLC		Darti		10f. Zip Code	•		10g.	Citizen of V	Vhat Coun	itry?	
-	5 0 8	a D	6401 N. Charles	Street			ľ	4	21212			II	S.A.		
Ser.	A Per	ner	11. Marital Status	12. Was Dece		U,S.	13. Was			? (Specify Yes or uerto Rican, etc.)	No-	14. Rac	e - Americ		
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2	ygier yer th	S		5+ ye	ars	Adn	nini	strati						·Educ	ation
Maryland	d di di di di di	Be	17. Fether's Name (First, Middle, Las	<i>t)</i>					18. Mother's	Neme (First, Midd	fle, Meid	len Sumem	ie)		
yla	Men Merke Merke	2	Ellis Denny						Marga		mch				
Mai	d 2 should h and Mer 7 is marke traumatic		19a. Informent's Name/Reletionship				_			r Rurel Route Nur					
	F Healt Heem 27 Other		Bernice Feilinger 20a. Method of Disposition	c, S.S.N				<ul> <li>Char</li> <li>On (Neme of</li> </ul>		Baltimor					
jor	80= 5		1 N Buriel 2 ☐ Cremetion 3 [		State	cemetery,	cremet	ory or other p	olace)	1000		Location -			
Baltimore,	emit. Pag epartment riportant: I ny Injury o nse.				V	illa l				7-12-97	7 G1	en An	m, Ma	ıryla	nd
Ba	Depa Impo any l	4 Donetion 5 Other (Specify)  Villa Maria Cemetery 7-12-97 Glen Arm, Ma  21. Signature of Funeral Service Licensee  22. Name end Address of Facility Mitchell-Wiedefeld Home													
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	Physiclan /Medical		Immediate Cause (Final	11		0	_							/	0 00011
1	Examiner		diseese or condition resulting in death)	a. (A.					0~				-	6 40	as
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	cate be executed physician and the burial-transit	Examiner	Cognosticille list conditions	b	Due to	(or es e co	neequer	oca of):				-			
ó	exec an an rial-tr		Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying		50010	(01 03 0 00	iisoquoi	ice oi).					!		
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IS,	res the signe	b										71			
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כ	Jing P. After funer	ion	1 X Natural 5 ☐ Pending		h, Dey Year)	28b. Tin	ury	28c. In W	vork? □ Yes 2 □ No	28d. Describ	e now ii	ijury occuri	ed		
Division	or Attending P sefer death.  Director: After to in by the funer.	Certification:	3 Suicide 6 Could not b	00 000	of Injuny - At	home ferm		factory, office		28f. Location	Street	end Numh	er or Rura	I Route M	ımher
S	efter Dire	ert	4 ☐ Homicide determined	buildir	ng, etc. (Spe	cify)	, 30000	ractory, offic	~	City or			0, 0, 11010	, , iodio , vi	3111001,
	spits nours neral		29a. Certifier 12 CertifyIng Pr	nysician: To the	best of my ki	nowledge, d	death oc	curred et the	time, dete end p	lace, end due to the	ne ceuse	e(s) end me	nner es st	eted.	
	To the Hospital or within 24 hours efter To the Funeral Dir completely filled in	edicai	(Check only 2 Medical Examone)	miner: On the be	sis of exemi	nation end/	or invest	igation, in m	y opinion, death o	occurred et the tim	e, date	and plece,	end due to	the ceuse	e(s)
	Withii To th	M	29b. Signature and life of certifier	) []				29c. Lice	ense number		29d.	Date signed	d (Month, i	Day, Year,	)
	2		Mux	Su	r			20	4126			7/51	57	,	
	5		30. Name and eddress of person who	completed ceus	e of death (It	em 23e) (Ty	ype, Prir		, , - 0			1-1	1-1		
_			Alberto Diaz, M.I	7401	0sler	Drive	To	owson.	Marylar	d 21204					
	Sta		31. Dete filed (Month, Day, Year)		egistrer's Sig			,	7						
	Registr	ar	JUL 1 4 1997	grene	evidson-	gandel	5								



State of Maryland / Department of Health and Mental Hygiene 97

29d. Date signed (Month, Day, Year)

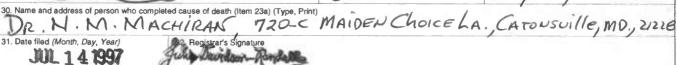
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						Cer	tificate	of i	Death		Reg. No.		Size B	1 7 0
Р	Dhuain	ian	1. Decedent's Name (First, Middle, La	st)						2. Date of	Death	Voor	3. T	ime of Death
	Physic /Medi		OLLIE L. D	ICKERSO	N					JULY	11.19	97 Year	4:	15 A.1
7	Exami		4a. Facility Name (If not institution, give 605 N. LOUDON		er)				SALTIM	, or Location of DIORE		unty of Deal	th	
Ī	Funeral Director		5. Social Security Number 219 03 1324A	Sex 7. I□M 2□XF	Age (In yrs. 94	last birthday) Yrs.	If Under	Year Days		Hrs. 8. Date of (Month)	Birth Day, Year) 27.190	9. Bird	thplace (S	State or Foreign
	p .	1	Usuel Residenca of Decedent							1				
	the Marytar 28s-f show notified at	ctor	MD. 10b. County			y, Town or Loc ALTIMO								ide City Limits Yes 2 □ No
	23 or 24	al Director	10e. Street and Number 605 N. LOUDO	N AVENU	E		10f. Zip (				10g. Citizen	of What Co		
020		Dy-Furter	11. Meritel Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Wes Decade Armed Force 1  Yes 2 If Yes, Give Year or Date	XNo		Vas Decade i Yes, speci	_	ispanic Orlgin n, Mexican, F Specify:	? (Specify Yes or Puerto Rican, etc.)		Race - Ame Black, Whit ecify:		
5-0	N	ite.	15. Decedent's E. (Specify only highest gre	ducation		16a. Deced	ent's Usual	Occup	ation during most o	functina	16b. Kind	of Business/		
2121	d within piene. r than	Comple	Elementary/Secondery (0-12)	College (1-40 N/A	or 5+)	life. L	O NOT use	retired	WORK		PRIV	ATE E	FAMI	LIES
P	of the vent,	Be C	17. Father's Name (First, Middle, Last,						18. Mother's	Name (First, Mid	dle, Maiden Sur	mame)		
yla	Ment Ment arked arked	2	CLARENCE DIC	KERSON					ADEI	L ANDE	RSON			
, Maryland	and 2 shr aith and 27 is m		19a. Informant's Name/Relationship ( $N\Delta \bigcap MT$ F. $TULL$		EB)				and Number o	or Rural Route Nu ΓΕ, ΒΔ	mber, City or To	wn, State, 2 EMD.	Zip Code) 21	229
Baltimore,	Pages 1.8 nent of His int: If them ary or other		20a. Method of Disposition  1 2 Burial 2 Cremation 3 4 Donation 5 Other (Specification)		te	Place of Disposemetery, crem	atory or oth	her plac		Date 5 / 9 7		on - City or		ate RYLAN
Balt	permit, Page Department of Important: If I any injury or stage.		21. Signature of Funeral Service trices	WIS T.	GWYNI		EWIS	Τ.		FUNER.				6393
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus one dause on each	sed the deat n line.	h. Do not ente	17 P	ARK of dyin	HEIC g, such as ca	HTS AV	E . BA	LTO.	Appro	oximate al Between
1	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  e. Widely METASTATIC INTRA-AbdomiNA/ MAligNANCY											e and Death
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90,	ertificate be executed ling physicien and se es the buriei-transit	i Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):											
68760,	rificate t ng physic es the t	Medicai	that initiated events resulting in death) Lest	<b>6.</b>	Due to (o	r as a consequ	ience of):					1		
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	the all	Physician/	Part II. Other eignificant conditions c							23b. C	old tobacco uee	contribute	to the cr	uae of death
s, P.O	requires that the death ce een signed by the attendi hould be datached for use	by Ph	GROSS EMACIA	TION.	MIT	RAI 1	USUF	FIC	iency	_ 1	□ Yes 2 X	lo 3 Pi	obably	4 Unknow
Records,	2 s b	Completed	Sevile Emp	hysem	A. L	FARLY	PARI	KINS	sons		as an autopsy erformed?		eveilable	opsy findings prior to in of cause
E B	The ate h	Con	DISEASE							1	□Yes 2 N	0	1 🗆 Yes	2) No
of Vital	ician: The lav certificate has rector, page 2	Be	25. Wes case referred to medical examiner?							Death (Check on	ly one)			
of	hysic this c	은	1 Yes 2 No	Hospital: 1 Inpa		ER/Outpatient			4 LI NUISI	ng Home 5 R			cify)	
Division	Attending Physicien: r death. ector: After this certific by the funeral director,	ation	27. Manner of Death  1 Natural 5 Pending investigation		Jury Day Year)	28b. Time of Injury	M 28	c. Injun Worl	rat <br Yes 2 □ No	28d. Descri	be how injury oc	curred		
Divis	• Hospital or Attending Physicien: The is 24 hours efter death. • Funeral Director: After this certificate he etaly filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	200. FIECE OF	Injury - At ho etc. (Specify	ome, farm, stre	et, factory,	office			n (Street and N Town, State)	um <i>ber</i> or Ru	ıral Route	Number,
	Hospital or 24 hours efte Funeral Dir etaly filled in	dical (	29a. Certifier (Check only one)  Certifying Ph 2 Medical Exam	yelclan: To the bea	of examina	wledge, deeth tion and/or Inve	occurred at estigation, i	the tim	e, date end p pinlon, death	lace, and due to to	he cause(s) end ne, date and pla	d menner es ca, and due	stated. to the ce	use(s)

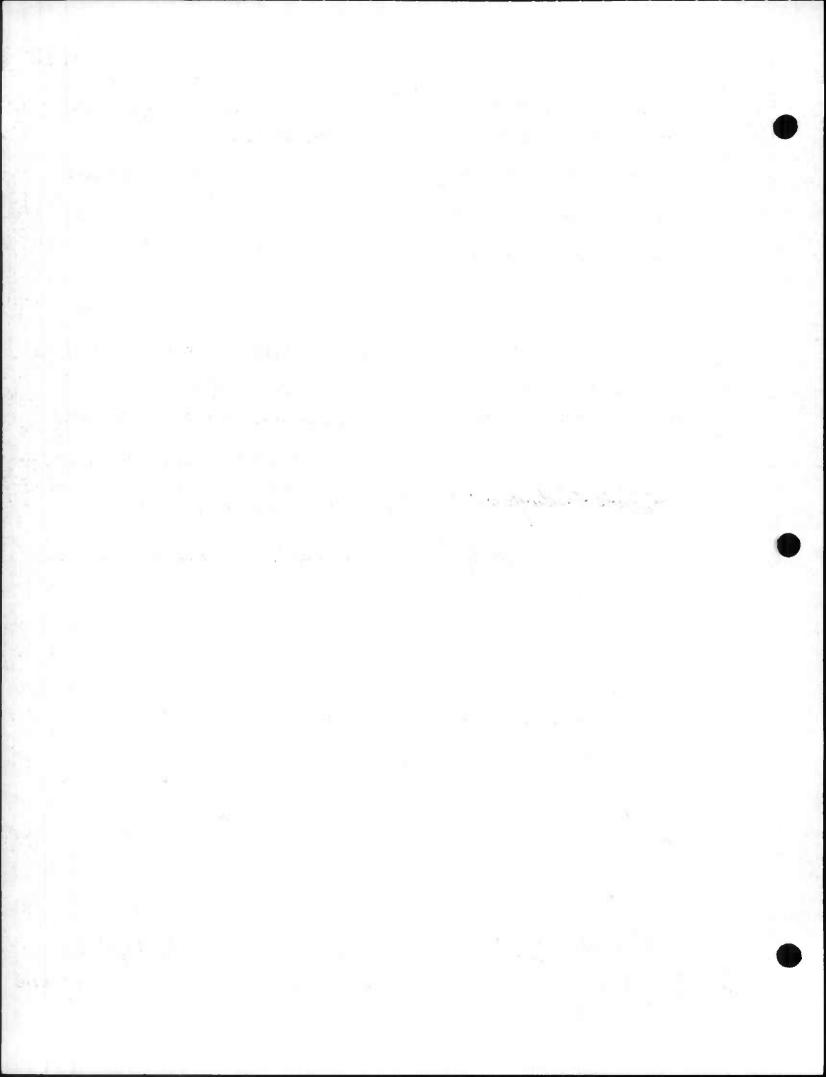
State Registrar

31. Date filed (Month, Day, Year) JUL 1 4 1997

29b. Signature and title of certifier

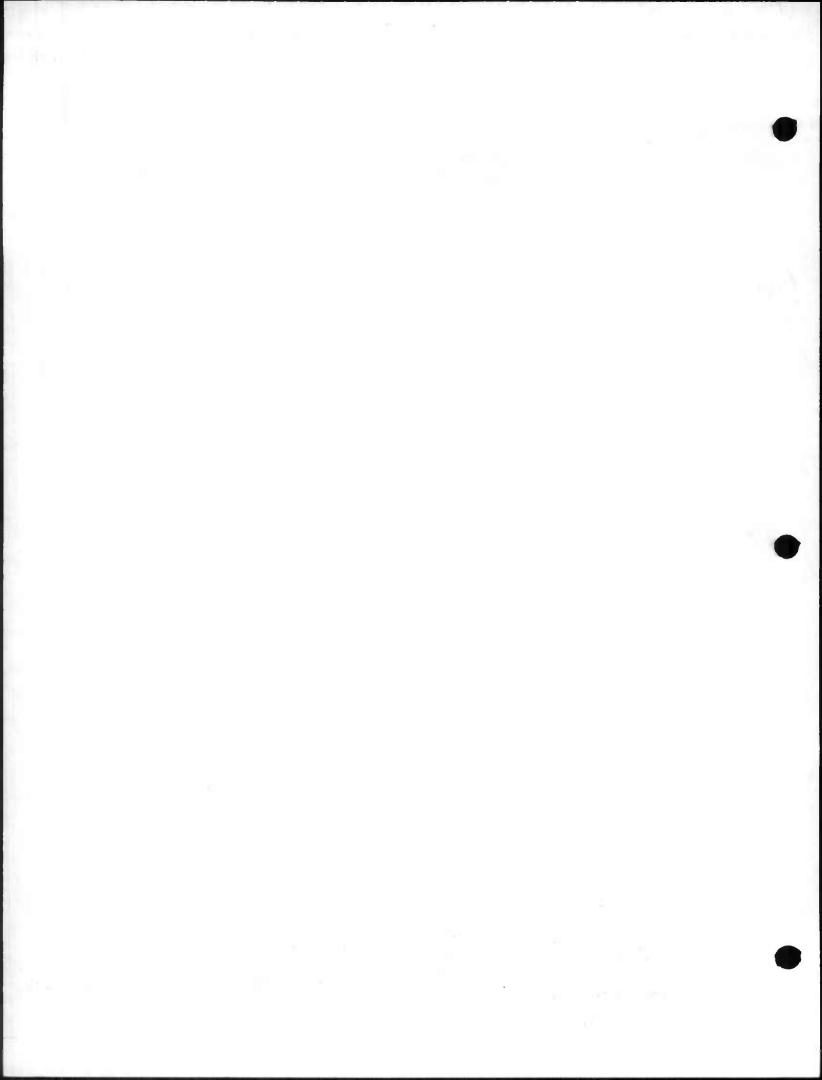


ATTENDING



CL	EAVON Items:2	3 a	DURANT part 1,27,28a-f per Me			epartment of I Dertificate of		Mental H	ygiene 9 Reg. No.	1	211/4
	Physici	an	Decedent's Name (First, Middla, Las     CLEAVON			50		2. Data of D Month JULY	Day	Yaar 997	3. Time of Death 7:00 A
	/Medio Examir		4a. Facility Name (If not institution, give 5528 WHITWOOL				4b. City, Town, or BALTIM	Location of Dea		of Death	7.00 A
	Funeral Director		210 70 7373		9 (In yrs. lest birtho	Months Days	If Under 24 Hr.	s. 8. Date of B	irth Pey, Year)	9. Birthp Cour	olaca (Stata or Foreign ntry) MD .
	Maryland of show fied at	tor	Usual Residence of Decedent  10a. State 10b. County  MD. N/A		10c. City, Town of BALTI						10d. Inside City Limits 1 ∰ Yas 2 ☐ No
_	with the Mar 23s or 28s-f st at be notified	al Director	10e. Street and Number 5528 WHITWOOD	ROAD		10f. Zip Code 212	06		10g. Citizen of		itry?
W		by Funeral	11. Marital Status  1 Navar Married Married  3 Widowed 4 Divorced	12. Was Decedent II Armed Forces? 1 ☐ Yas 2 ☐ N If Yes, Give Yaar or Dates:		13. Was Decedent of I If Yas, specify Cub 1☐ Yes 2∰ No	an, Maxican, Pue	Specify Yes or N rto Rican, etc.)		ck, Whita,	ean Indian, atc. AFRO ERICAN
21218-0	within 15 hp iene. than 'netth the Medical	Completed	15. Decedent's Edi (Specify only highest gred Etementary/Secondary (0-12)		(0)	ecedant's Usual Occu Give kind of work done fe. DO NOT use retire FORM ANA	pation during most of we d) LYST	orking	16b. Kind of B		
Maryland 2	should be filed and Mental Hyg marked other matic event, i	To Be C	17. Fathar's Name (First, Middla, Last)  TOM DURA	NT		7000	18. Mother's Na	or or or or or or or or or or or or or o	e, Meiden Sumer	ne)	
	feelth and feelth and m 27 is me her traums		19a. Informant's Name/Relationship (7) KAREN A. DURANT	ype, Print) WIFE	5!	Meiling Address (Stree		BALTO.	MD. 21	206	
Baltimore,	artment of hortant: If the injury or of the		20a. Method of Disposition  1		cemetery,	isposition (Name of cremetory or other pla  WN MEM. P.  22. Nama and Addre	ARK	7/9/97	BALTO		iwn, Stata
Ba	Deper Impo Impo Brny i		23a. Part : Enter the disease, or comp shock, or heert feiture. List only o	1 0	the death. Do not	FSTFP RI	POTHEDS	FUNERAL	HOME P./	١.	Annrovimate
	Physician /Medical Examiner		shock, or heert feiture. List only of Immediate Cause (Final disaase or condition resulting in death)		INTOXICAT						Approximate Intarval Between Onset and Death
	cuted nd ransit	Examiner	Sequentially list conditions	b		(or as a consequence of):  (or as a consequence of):					
68760,	ificate be executed g physician and as the buriai-transit	edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet Initiated events rasulting in death) Last	c							
Box	requires that the death certifica een signed by the attending pl hould be detached for use as t	Physician/M	Part II. Other significant conditions co	dntributing to death bu	t not resulting In th	na underlying cause gi	ven in Part I.	23b. Did	d tobacco use co	ntribute to	o the causa of death?
ls, P.O	res that the designed by the	þ						1	Yes 2 No	3 □ Pro	
Records,	e law has b	Completed						24a. Wa per	s an autopsy formed?	av	ere autopsy findings railable prior to omplation of cause death?
	Physician: The is this certificate ha	To Be Co	25. Wes case referred to medical examiner?  1X Yes 2 □ No	-fospital: 1 ☐ Inpatie	at 2 EP/Outo	atient 3 DOA Ot	hor:	eath (Check only	Yes 2□ No one) sidence 8 □Oth	or /Specif	Yes 2□ No
Division of	tending leath. tor: After the fune	Certification: T	27. Manner of Deeth 1 □ Natural 5 □ Pending 2 □ Accident 3 □ Suicide 4 □ Homicide 5 □ Could not be determined	28e. Dete of Injur (Month, Day found 7/4/9	y 28b. Tim Year) 28b. Tim Inju 97 found ry - At home, farm (Specify)	ne of A 28c. Inju		28d. Describe unknown 28f. Location City or To	Street end Numbown, State 5528	per or Rura Whit	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical		sician: To tha best o	f my knowledge, d examination and/o	leath occurred et the ti or Investigation, in my (		e, end due to the	e ceuse(s) end me	enner es s	
	Tot Total		29b. Signatura and title of certifiar	11. 1	78-0	Ki	.M.E		29d. Date signe		
	10		30. Name and address of person who co	14	111	Penn St	reet, E	Baltimo	re, Ma	ryla	nd 21201
	Sta Registr	re.	31. Date filed (Month, Day, Yeer)  JUL 1 4 1997	Julia David	son-Randel	è.					

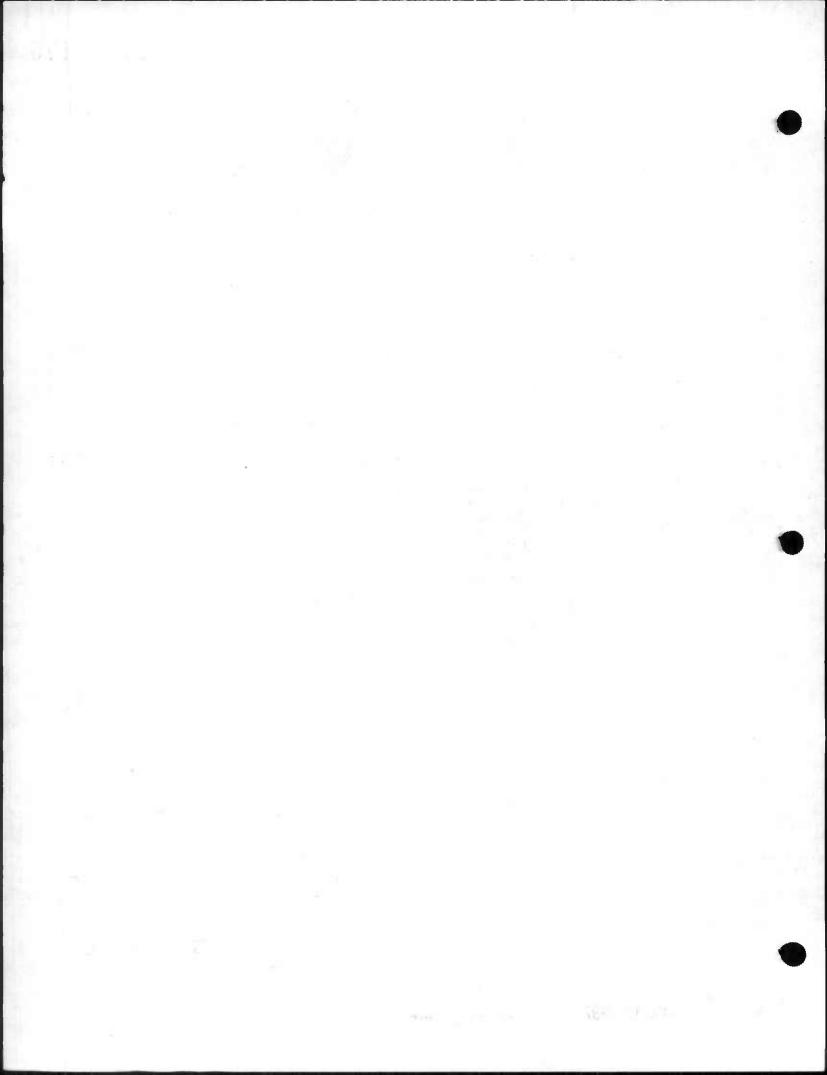
DHMH 16 Rev 6/95



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene 97

					.,	Certificate		mornar rry	Reg. No.		6117	U	
г	Dhysia	ian	1. Decedent's Nama (First, Middla, L	ast)			10	2. Data of De	eath Day	Year	3. Tima of Da	ath	
	Physic /Medi		KOSCOŁ			EVAL	VS	July	12	1897	1:30	P	
j	Exami	ner	4a. Facility Nama (If not institution, g	ALL DAY SHOOL TO SEE			4b. City, Town, or	Location of Deat	h 4c. County	of Death			
			Mercy/Stella				Baltimo			n/a			
	Funeral Director		5. Social Sacurity Number 6. 220 – 22 – 6362  Usual Residence of Decadent	\$9x	(In yrs. last bir	Yrs. If Under 1 Months	Year If Undar 24 Hrs Days Hours Min.	8. Deta of Bir Month, De July	<sup>th</sup> Yaar) 23,192	9. Birthpl County	lace (Stata or Fo try) MD	oraign	
	wo #		10a. Stata 10b. County		10c. City, Town	n or Location				1/	0d. Insida City L	imits	
	Mary I-f sh	Ö	MD n/a		Balt	cimore					1∏%as 2[	□No	
	h the	rec	10e. Street end Number			10f. Zip C	oda		10g. Citizan of W	Vhat Coun	try?	-	
	th wit	a	2233 Reisters	town Rd.			21217		U	SA			
Maryland 21215-0020	72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show houses Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Navar Marriad 2 ☑ Marriad 3 □ Widowed 4 □ Divorced	12. Was Dacedent Ev Armed Forcas? 1. Head Forcas? 1. Head Force Property of the Property of t		13. Was Dacedar if Yas, specify	nt of Hispenic Origin? (S y Cuban, Maxican, Puerl No Spacify:	pecify Yes or No to Rican, atc.)		- Amarica k, Whita, a Bla	atc.		
2-0	hin 72 ho s. nn "natur Mexical	Completed	15. Decedant's E	ducetion	16e.	Decedent's Usual (	Occupation	4.1	16b. Kind of Bu	siness/Ind	lustry		
21	within 7	nple	(Spacify only highast g Elementary/Secondary (0-12)	Collega (1-4or 5+	1		Occupation done during most of wor retired)	rking					
2	77 75 1	Co	11th		Pc	ostal Wo					Office	è	
and	od is o	Be	17. Father's Nama (First, Middle, Les	P					Maidan Sumam	e)			
2	d 2 should be it and Mental 7 is marked of fraumatic ev	10	John Henry Ev			A	Drucil						
Ma	d 2 a d 7 ls a f T ls		19a. Informant's Name/Ralationship		i		Straat and Number or Ru						
	- F E E		Dorothy Evans 20a. Mathod of Disposition		20b. Place of	Disposition (Nama	etown Rd.	Pasace	20c. Locetion				
Baltimore,	20 Pt 100		1 ☐ Burial 2 ☐ Sremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Space			y, cramatory or other							
₫			21. Square of Funeral Service Mor	**	Metro	22. Nama end	Address of Facility	7/14			le, MD	,	
ä	permit. Depart Import any inj gds.		( Vames G	hat.		James	A. Morton aurens St	& Son	s Funer	ral	Home 217		
	THE H		23a. Part V Inter the disaasa, or cor shoot or haart failura. List only	nplications that coused the	na daath. Do r						Approximata Intarval Batwaa		
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7	/Medical Examiner		Immediate Causa (Finai disaasa or condition	a BRAIN	Mi	TAST A	Sis				4 mon	Th	
п	LAAMINE	<b>.</b>	rasulting in daath)	LUNG	ua to (or es e o	consequance of):					4 mon	10	
	pe jisi	nlne		b. LUNG	CA	NOER					mon	tho	
	and and II-tran	xan	Sequentially list conditions, if any, leading to immediate	D	ua to (or es a c	onsaquence of):							
68760,	rificate be executed 19 physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, laading to immadiata ceusa. Entar Underlying Causa (Diseasa or Injury that initiated events	C									
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P.O.	that the death cei ed by the attandir detached for use	Physician/M					ou grown are are		Yes 2 No		1.		
'n	as tha igned be de	by											
Records,	requir been s should	Completed							24a. Wes perfo	an autopsy mad?	eve	ra autopsy findir ilable prior to nplation of cause laath?	
	The ate h	50						10	ras 2 No	1□	Yas 2□ No		
/ita	ysician: The lav is certificate has director, page 2	Be	25. Was cesa rafarred to medicel axeminar?				26. Place of Daa	th (Check only o	1	In MA	Ris At	MEA	
5	hyslo this c	2	1□ Yas 2NNo	Hospital: 1 Inpatient				ome 5 Rasio	dance 6 Otha	r (Specify	Hospic	CE	
ב	Ing F	Certification:	27. Mannar of Death  1 Naturel 5 □ Panding	28a. Dete of Injury (Month, Day )	(ear) 28b. T	njury	Injury at Work?	28d. Dascribe I	now injury occurre	∌d	,		
Sic	death death tor: /	Cat	2 Accidant Investigation 3 Suicide 6 Could not to	On Place of Injury	At home for	M 1 Yes 2 No				or or Press	Doute Mumber		
Division of Vital	or Attending after death. Director: After I in by the fune	ert	4 ☐ Homicida datermined	building, atc.		m, straat, factory, o	опісе	City or Tov	Straat and Numbe vn, Stete)	or murai	Houta Number,		
	To the Hospital or Attending Physicians, within 24 hours after deals.  To the Funeral Director: After this certifical completely filled in by the funeral director,		29a. Certifiar 1 Certifying Pl	nysician: To the best of r	ny knowledce	death occurred at t	the time date and alone	and due to the	nauca(e) and mi-	nnar oo ot	atad		
	• Hon 124 h • Fur	edical	(Check only 2 Medicei Examone)	niner: On the besis of a and manner state	kamination and	Vor Invastigation, in	my opinion, daath occu-	rred at tha time,	data and place, a	nd dua to	the ceuse(s)		
	withir To th	Me	29b. Signature end titla of certifiar			29c. L	icensa number		29d. Data signed	(Month, L	ley, Year)		
	7		20. 20	5 mg			240480	-	July 1	4, 19	197		
	20	-	30. Nama and address of person who	complated ceusa ot dea	th (Item 23a) (	Type, Print)	D40480 5810 BE BALTO, M.	2412 2	20	, , ,			
	W		FERNANDO	J. FERRO	no		BAZTO, 11.	D 2/2	06				
	Sta Registr		31. Data filed (Month, Day, Year)  JUL 1 4 1997	32. Registrar's	Signetura	82							

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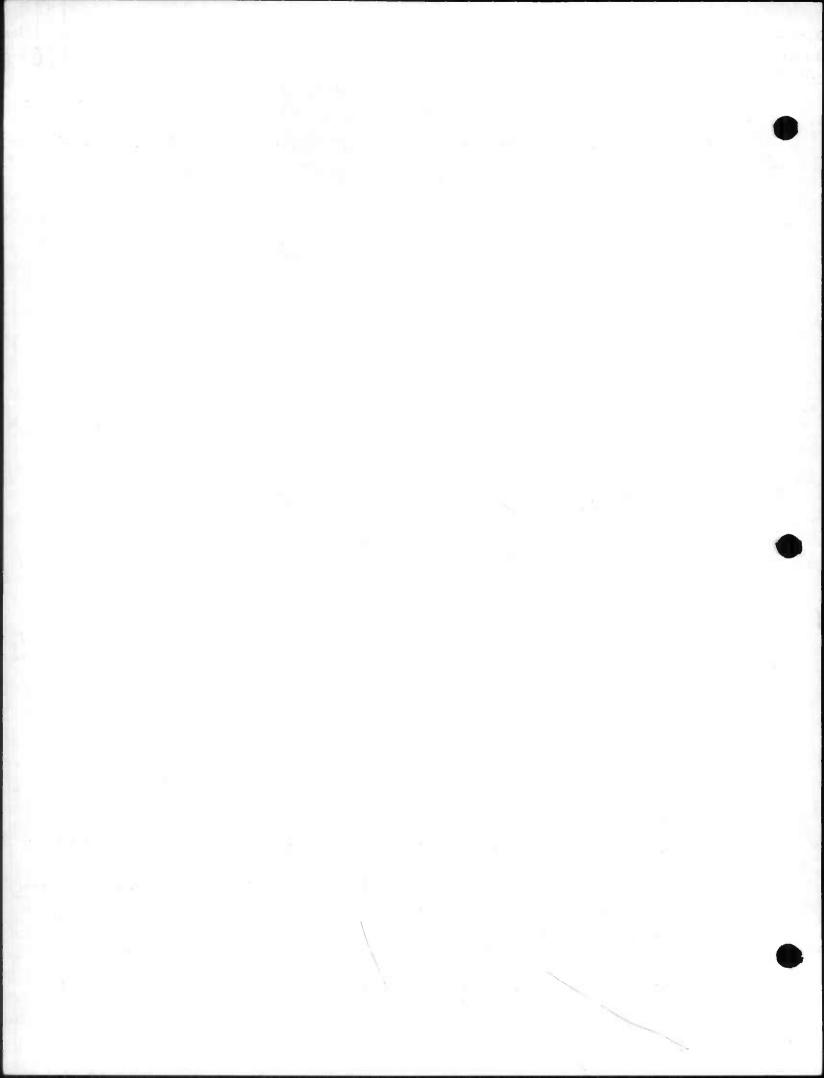


State of Maryland / Department of Health and Mental Hygiene 97

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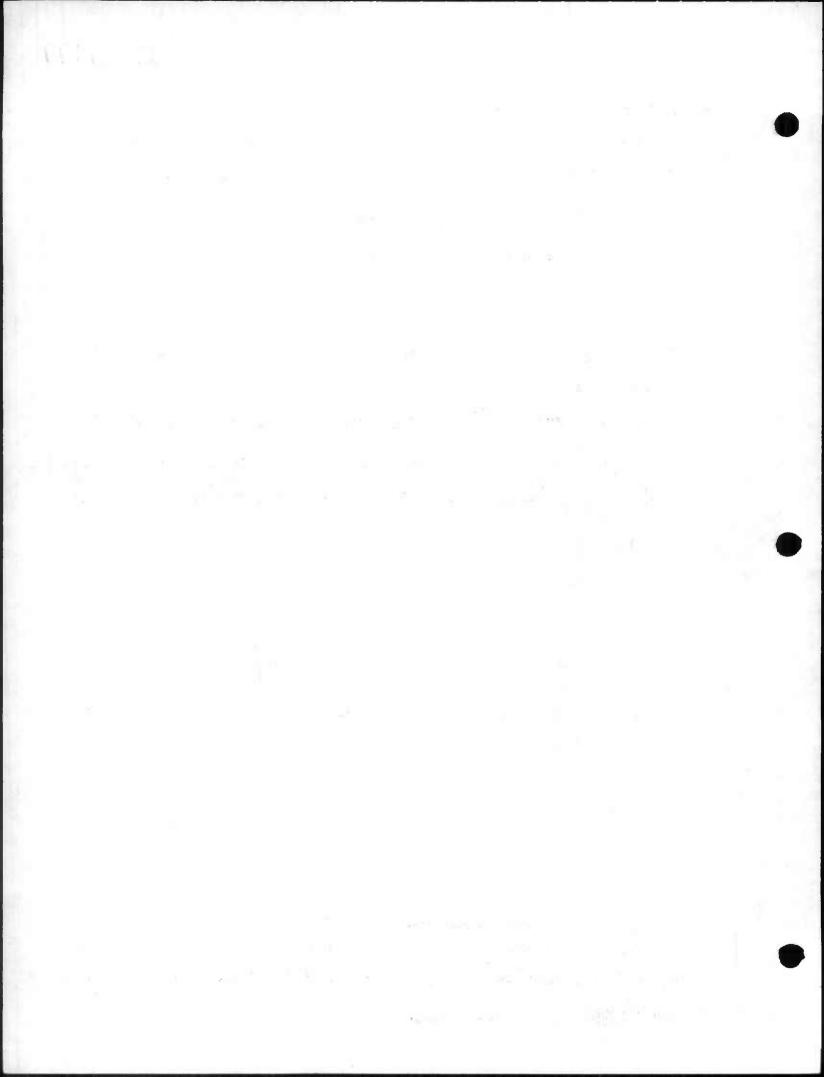
			,	Certificate of Death	Reg. No.	21110		
	<b>-</b>		Decedent's Name (First, Middle, Last)		2. Dete of Deeth	3. Tima of Death		
	Physici /Medi		ETHEL LEE SHELLY	FENTRESS	Month Day Year	09:30pm		
	Examir		4e. Fecility Name (If not institution, give straat and number)	4b. City, Town, or	A TABLE SCHOOL STATE OF THE PARTY OF THE PAR	eth		
		В	LAUREL REGIONAL HUSPITA	<u> </u>	(1111000	heorgies		
	Funeral Director		5. Sociel Security Number  6. Sax 1 M 2 F 7. Age (In yrs. last birth 430 - 05 - 3240  Usuel Residence of Decedent	hday) If Under 1 Yaar If Undar 24 Hrs. Months Deys Hours Min.	(Month, Day, Year)	irthplace (State or Foreign Country) He Rock JAR		
	yland		10e. Stete 10b. County 10c. City, Town	or Location		10d. Inside City Limits		
	a Mar	to	Ih Ma C	nicago		1 ☐ Yes 2 No		
	s 1 and 2 should be filed within 72 hours aftar daath with tha Maryland f Haalth and Mantal Hygiane. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Exaction must be recitled at	Funeral Director	1520 N. Wieland Str	eet 101. zipeode (e 0 le 11	10g. Citizen of Whet C			
	terne 23a	Iner	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forcas?	13. Was Decedent of Hispanic Orlgin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yas or No- to Rican, etc.) 14. Race - Arr Black, Wh			
21215-0020	n 72 hours aftai "natural", or it	by	1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yas, Give Yeer or Detes:	1 Yes 2 No Specify:	Specify:	3 lack		
5-(	72 h	Completed	15. Decadent's Education 16a. ( Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	rking 16b. Kind of Busines	s/Industry		
121	within the.	mp	Elettrefiltery/Secondary (U-12)   College (1-40r5+)	life. DO NOT use retired)	Ker Fac	toris		
	Hygia Hygia ther t		17. Fathar's Name (First, Middle, Last)	PUCTORY WOLL	me (First, Middle, Maiden Sumame)	7		
Maryland	2 should be filed within and Mantal Hygiane. is marked other than sumatic event, the Mannatic event.	Be	Dialand Start	d/ara				
Z	should be nd Mantal marked o	2	19a. Informant's Name/Relationship (Type, Print) // 19b.	Mailing Address (Street and Number or Ru		Zin Code)		
M	and 2 saalth ar		Maria Mc Davial - Grang 1	979 Martain 1	Ermia Lourel	1010 20404		
re,	s 1 and if Haalth Item 27 other tr		20e. Method of Disposition 20b. Place of	Disposition (Name of	Date 20c. Location - City o	r Town, Stete		
Baltimore,	@ 0		1 ⊠ Burlal 2 □ Cremation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify)	r, crematory or other place)	Ship Tili	NOIS.		
			21. Signatura of Funaral Servica Licensee	22. Name and Addrass of Facility	7-15-91	7013,		
B	permit. Departrimports any inju		bull of the second	March F. H. We	ot de la la	2-14011		
	_		23a. Pert1. Enter the disease, oxcomplications that caused the deeth. Do no	ot anter the mode of dylng, such es cardier	cor respiretory arrest.	Approximete		
	Physician		23a. Pert1. Enter the disease, of complications that caused the deeth. Do no shock, or heert failura. List only one causa on each lina.	The state of the s	or respiretory arrest,	Intervel Between Onset end Deeth		
	/Medical		trimediate Cause (Final disease or condition MULTIPLE INC	illine o				
	Examiner		disease or condition resulting in death)  Due to (or as e co			1		
	D ==	ner	200 to (0. 400 0 to	modulino dij.				
	tificete be axecuted og physician end as the buriel-transit	Examiner	Sequentially list conditions, Due to (or es e co	onsequenca of):				
90,	se axe	û	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury					
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	# 0 m	Me	d					
Box	eath cert attendin I for usa	Physician/N						
o.	t the de by tha a tached	ıysi	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given In Pert I.	23b. Did tobacco use contribut			
0	that ded by				1 Yes 2 No 3 1	Probably 4 Unknown		
Vital Records,	The law raquires that the death cer ste hes been signed by tha attendir paga 2 should be datached for usa	d by				. Were eutopsy findings		
00	w raquire been si should I	Completed			performed?	eveilable prior to completion of cause of deeth?		
Re	The law ete hes page 2 s	mc			1 ☐ Yes 2 🕱 No			
ta		Be C	25. Was case referred to medical	26 Place of Day	1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No		
$\leq$		0	examiner?	Other	lome 5 ☐ Residenca 6 ☐ Othar (Sp	ecify)		
0 ر	ding Phys h. After this funaral d	T:u	27. Manner of Death 28a. Date of Injury 28b. Ti		28d. Describe how injury occurred			
Ö	Attending or death.  • ctor: After by the fune	atic	2D Accident investigation 07-09-97 09	1 Yes 2 No	OCCUPANT OF AUTO VS			
Division	or Attending after daath.  Director: After da in by tha fu	Certification:	3 ☐ Suicide 6 ☐ Could not ba 4 ☐ Homicide determined 28e. Place of Injury - At home, farr building, etc. (Specify)	n, street, factory, offica	28f. Location (Street and Number or F City or Town, State)	Rural Route Number,		
۵	ital o	S		STREET	RT 198 & VAN DUBEN	RD, LAUREL		
	To the Hospital or A within 24 hours after To the Funaral Dire complately filled in b	edical	29a. Certifier (Check only  Medical Examiner: On the best of my knowledge,  2 Medical Examiner: On the best of examination and	deeth occurred et the time, dele end plece for Investigation, in my opinion, death occu	, end due to the ceuse(s) and menner e	es steted. ue to the ceuse(s)		
	thin 2 the the	Med	one) and manner stated  29b. Signature and title of certifier					
	L 3 L 8	-	EUR. Signatura and title of Certified	29c. License number	29d. Date signed (Mor	ini, Day, Tear)		
	20		Constant de des	ME V 33954	JULY 11,	1997		
	\v\		30. Name and address of person who completed cause of death Utem 23e) (T		1157 4570	0 0000		
			MARIO F. GULW JR MV 3001  31. Date filed (Month, Day, Year)  32. Registrer's Signatura	HOSPITAL PRIVE, C	heverly indryid	NV 10 185		
	Sta Registr	_	St. Sale med (worth, Day, Year)					

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 97 21177

Maria La La		1. Decedent's Name (First, Middle,	_			M 1		2. Date of Do	eath Da	y Yeer	3. Time of Death
Physicia /Medica		SALLY L.	FOREMAN	)				York	10		
Examine		4e. Fecility Neme (If not institution,	give street and numb	oer)			4b. City, Town, o	Location of Dea	th 4c	County of Dec	eth
		MARYLAND	GENERAL	- Ho:	SPITAL		BALTIMO	RE		BAL	TIMORE
ineral		5. Social Security Number 6	. Sex 7.	Age (In yrs.	last birthday)	If Under 1 Ye	ar If Under 24 Hr	s. 8. Date of Bi	rth	9. B <u>i</u>	irthplece (State or Foreig
ector		219 - 30 - 9908-A Usual Residence of Decedent	1□ M 2 🗓 F	95	Yrs.	Months Dey	ys Hours Mir	n. (Month, D 02 - 1	ey, Year)	0)	C.
11	- 1	10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limit
notified at	ö	MD N/A		1	3ALT11	nore					1 Yes 2 N
III I	Director	10e. Street end Number			7110711	10f. Zip Code			10a Cit	izen of Whet C	`aunta O
8 (		5200 Kenilworth	Avenue			21212			U.S		ountry
	Funeral	11. Maritel Status	12. Wes Decede Armed Force	ent Ever in U,	.S. 13. V	Vas Decedent of	f Hispanic Orlgin? ( uban, Mexicen, Pue	Specify Yes or No	0-	14. Raca - Am Bleck, Wh	
	by Fu	1 Never Married 2 Married 3 M Widowed 4 Divorced		<b>⊠</b> No		☐ Yes 2030N		110 1 110211, 010.7		SpecifyBla	
	Be Completed	15. Decedent's (Specify only highest (	Education grade completed)		16a. Deced	lent's Usuel Occ	supetion ne during most of wi	orking	16b. K	ind of Business	s/industry
	dr.	Elementery/Secondary (0-12)	College (1-4	or 5+)			ired)				
	Ö.	8th grade  17. Fether's Neme (First, Middle, La			Domes	tic			Priv	rate Fa	milies
Les l	98						18. Mother's Na	ame (First, Middle	, Maiden	Sumeme)	
	0	William Louis C	arson				Vinnie	Staley			
		19a. Informant's Name/Relationship	(Type, Print) Si	ster	19b. Mailin	g Address (Stre	et end Number or F	Rural Route Numb	per, City o	r Town, State,	Zip Code)
		Phyllis M. Bagw	ell				orth Aven				
		20a. Method of Disposition		20b. P	lace of Dispos	sition (Name of		Date		ocation - City o	
		Burial 2 ☐ Cremation 3	☐Removal from Sta	ate		natory or other p	•				
	-	4 Donation 5 Other (Spec	1	Arb		emorial		July 16	Balt	imore	County, Md
9008	- 1	21. Signature of Funeral Service Lic	ensee	1	22.	. Name and Add	Iress of Fecility N	lutter Fi	mera	al Home	s. Inc.
H 20		11/2/	0/4	1.0	25	01 Gwyn	ns Falls				•
	1	23a. Rent Early the disease, or co shock, or head failure. List on	mplications that cau	sed the deeth						20, 110	. 2.210
ian		shock, or hear failure. List on	ACORR CAUSE OR SAC		<ol> <li>Do not ente</li> </ol>	at the mode of a	ying, such as cardia	ac or respiretory e	errest,		Approximete
1111		/	y sin organ ar our	h line.	1. Do not ente	ar the mode of d	ying, such as cardia	ac or respiretory e	errest,		Approximete Intervel Between Onset end Death
al		Immediate/Cause /Final	8 8							0	Approximate Intervel Between Onset and Death
		Immediate Cause (Final disease of condition resulting in death)	8 8							live)	Intervel Between
er .		Immediate Cause (Final disease of condition resulting in death)	8 8	HF		ngesli	ying, such as cardia			live)	Intervel Between
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amino.	niner	disease of condition resulting in death)	e	Due to (or	(Co	ngesli				live)	Intervel Between
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Month OSEPH 15-12 FEXILIERSTONE 4a. Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Daath University Of Maryland Hospital Baltimore 7. Aga (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 5. Social Sacurity Number Birthplace (State or Foraign Country) 8. Data of Birth (Month, Day, Year) 1□M 2□F XX Days Hours 239-20-1899 VA Usual Rasidanca of Decedant 10a Stata 10b County 10c. City, Town or Location 10d. Inside City Limits MD NA Baltimore 1 Yas 2 □ No 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 765 McKewin Avenue 21218 USA 12. Was Decedant Ever in U,S Armad Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amaricen Indian, Black, White, etc. 1 ☐ Yes 2大 No If Yas, Giva Yaar or Datas: 1 ☐ Naver Marriad 2 ☑ Married 1 ☐ Yas XXNo Specify: Specify: Black 3 ☐ Widowad 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry College (1-4or 5+) Elamantery/Secondery (0-12) Sanitation Driver Baltimore City 6th Grade 17. Fether's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Willie Featherstone Ella Miles 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) 21218 Faybell Featherstone 765 McKewin Avenue Baltimore, Maryland 20b. Place of Disposition (Nama of cematary, cramatory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Burial 2 Cramation 3 Removal from Steta 4 Donation 5 Other (Specify) Arbutus Mem. Pk. Cem. 07-12-97 Arbutus, Md. 21. Signatura of Funerel Service Licenses 22. Nama and Addrass of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue 23a. Part1. Entar tha disaasa, or complications that ceusad tha daath. Do not antar the mode of dying, such as cardiac or respiretory errest, shock, or haart failura. List only one cause on each line. Approximata Intarval Batween Onsat and Deeth Immediata Causa (Final EPFBEXL VASCUME ACCIDENT disaase or condition rasulting in daath) Due to (or es e consequence of) 10 FRETERGO Sequentially list conditions, if any, laading to immadiata ceusa. Entar UndarlyIng Ceusa (Disaasa or injury that initiatad events resulting in daath) Last Dua to (or as a consaguance of): Dua to (or as e consaquance of): Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown VASCULATE 24b. Were eutopsy findings availebla prior to completion of cause of death? 24a. Was an autopsy performed? INFATTCHO! MYOCKEDIAZ

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Completed

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7 is marked other than "natural", or items 23s or 28s-f shot traumatic event, the Wodical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "naturel", or Item any injury or other traumatic event, the Wedical Examine

Saltimore, Maryland 21215-0020

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death

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Box 68760,

Division of Vital Records, P.O.

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certificate 붙 Affler Director Nours atter

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Certification:

Medical

25. Was casa referred to medical examinar?

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5 Panding

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6 Could not be determined

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27. Mannar of Death

1 ANatural 2 Accident

3 Suicida

4 Homicida

1 ☐ Yes 2 ☐ No

26. Placa of Death (Check only ona)

Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 28c. Injury et Work? 28d. Describe how Injury occurred

281. Location (Street and Number or Rural Routa Number, City or Town, State)

Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Certifier 29b. Signature and title of garatter

1 N Inpatiant 2 □ ER/Outpatient 3 □ DOA

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

28b. Tima of

XU4176435 CE662

29c. Licansa numbar

29d. Data signed (Month, Day, Yaar)

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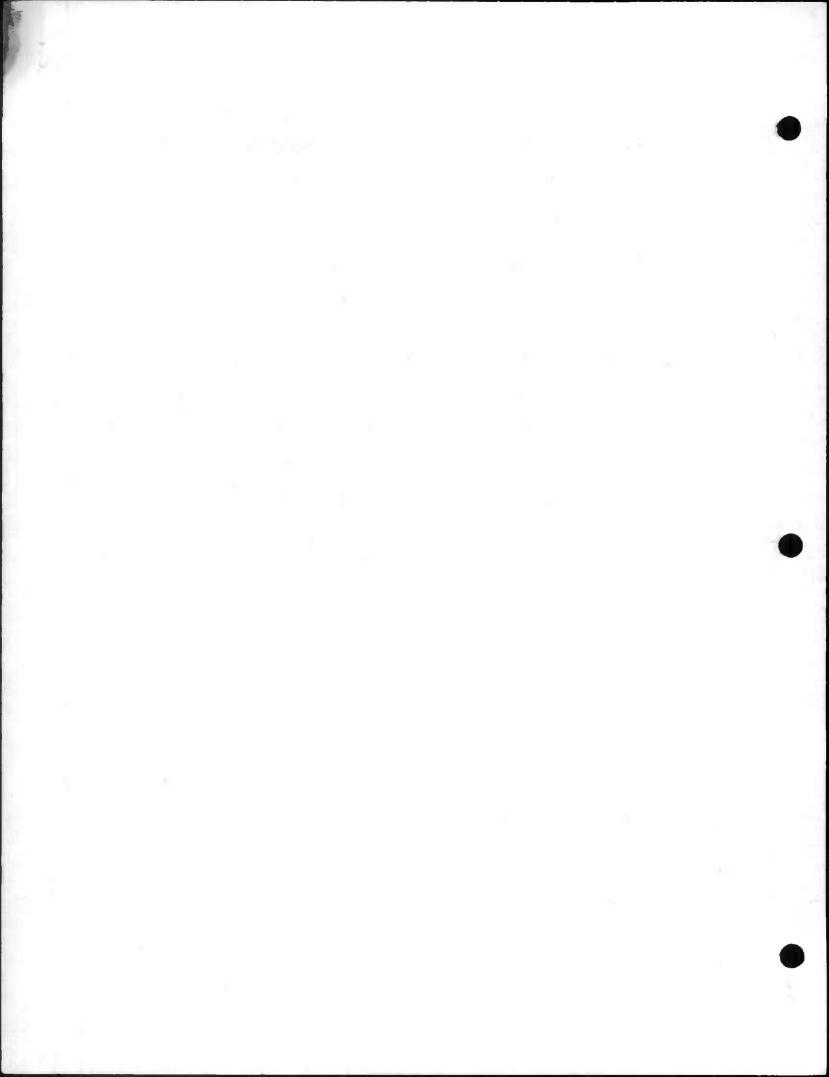
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State Registrar

To the Hospital Within 24 hours a To the Funeral D

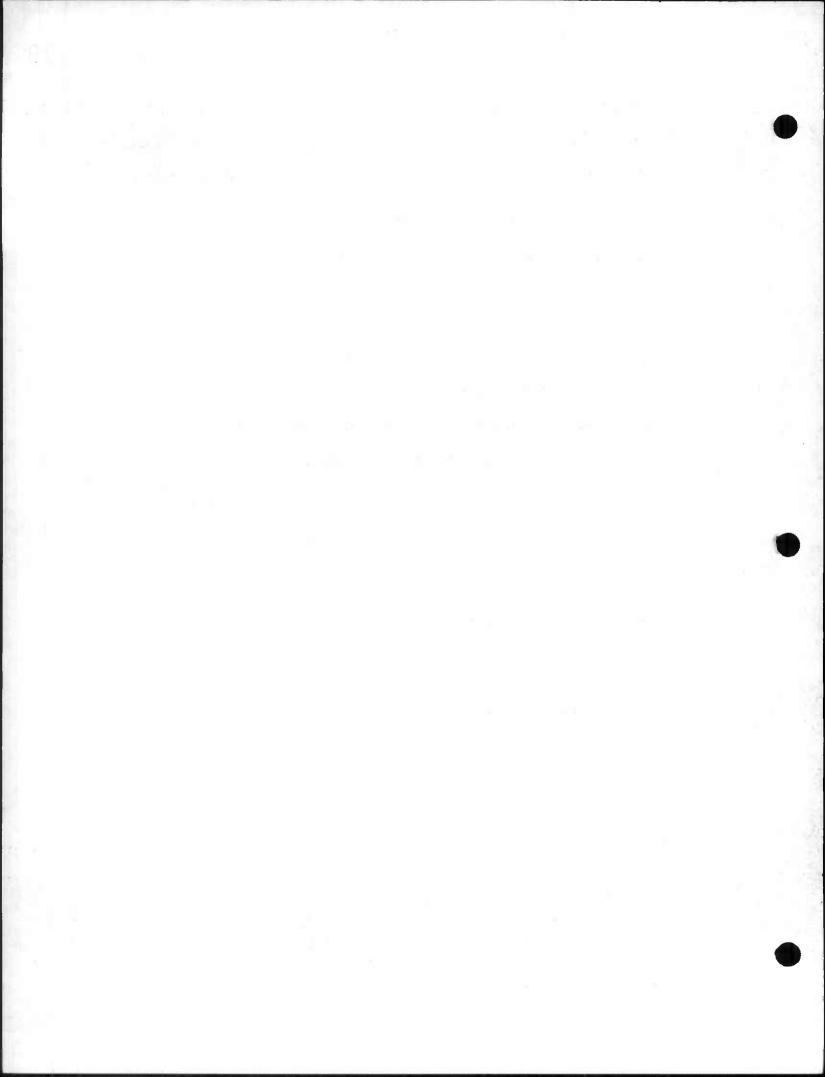


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Month ELEANOR LHOYD 10 2:10 AM JULY /Medical 4e. Facility Name (If not institution, giva straet and number, 4b. City, Town, or Location of Deeth 4c. County of Death Examiner HOSPITAL HRUNDEL NORTH GLEN BURNIE ANNE RUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Sacurity Numbar 7. Age (In yrs. last birthday) 6. Sax Birthplaca (Stata or Foraign Country) **Funeral** 1□ M 2XF Days Hours 83 Yrs. Director 218 07 7994 11, 1914 Maryland Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Anne Arundel Baltimore 10e. Streat end Number 10f. Zip Coda 10g. Citizan of What Country? 602 Surfside Avenue 21225 U.S. Funeral 12. Was Dacedent Ever in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Spacify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 ☐ Yas 2 XNo If Yas, Giva Yaar or Datas: 1 □ Navar Married 2 □ Marriad 215-0020 1 ☐ Yas 2 Z No Specify: þ Specify: White 3 X Widowad 4 ☐ Divorced Completed 16a. Dacedant's Usual Occupetion (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Spacify only highast grade complated) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) College (1-4or 5+) 10th Home Maker Own Home 17. Fathar's Neme (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Fo.Be Josephine Costa Ottivio C. Ormanno 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) 605 Biscay Avenue Baltimore, Maryland 21225 Laura E. Evans / daughter altimore, If Item 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata | Donation | 2 | Cramation | 3 | Removed from Stata | Cematary, cramatory or other place) | Cedar Hill Cemetery 7/12/97 Baltimore, Maryland 21. Signature of Funaral Sarvice Licensae 22. Nama and Address of Fecility Gonce Funeral Home P.A. Part 1. Enter the disaasa, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only a cause on each line. Baltimore, Md. 21225 Onset end Daath **Physician** /Medical Immediate Ceusa (Final disaasa or condition resulting in death) Examiner ettending physician and for use es the buriel-trensit The lew requires that the death certificate be executed Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Disaase or Injury that initiated avants rasulting in death) Last SEPTICSONA P.O. Box 68760 Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HED A71715. signed I Records, 24b. Wara autopsy findings evailable prior to complation of cause of daath? Be Completed 24a. Was an autopsy performed? pege 2 s 1 Yas 2 No 2)(1 No certificate Division of Vital or Attending Physician: efter death. 25. Wes casa rafarrad to medical axaminar?

1 Yes 2 No 26. Place of Daath (Chack only ona) Hospital: Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After 5 Pending invastigation Natural Accident 1 Yes 2 No Director: / 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 4 HomicIde To the Hospital or within 24 hours eff To the Funerel DI completely filled in edical ( 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier 29b. Signatura and titla of certifier 29c. Licansa number 29d. Data signad (Month, Dey, Yeer) 1 Loves m-D Q422(8) 30. Nama and address of parson who complated causa of death (Itam 23a) (Type, Print) RANDAUSTONA 4306 PIHEFIELD 160 PA, E. O

State Registrar 31. Date filed (Month, Day, Yaar)

32. Registrer's Signatura



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Yeer Benjamin Fleet 07-04-97 9:00AM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner BALTIMORE BAY AREA HOSPICE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey.) | 8/1/10 Birthplece (State or Foreign Country)
 MD . 5. Sociei Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** 1√2 M 2□ F Yrs Director 86 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1∰ Yes 2□ No MD. N/A BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? USA 2611 HOLLIN FERRY ROAD Fundraf 21230 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. A C 11. Marital Stetus 1 # Yes 2 No 12/42 It Yes, Give Year or Dates: 10/45 AFR0 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1□Yes 2# No Specify: Specify: AMERICAN ğ 3 ∰ Widowed 4 □ Divorced 10/45 Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry R (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) MD. GLASS CO. Boilerman (RETIRED) parmit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If farm 27 is merked offsi any injury or other traumatic event stock. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be BENJAMIN FLEET KATHERINE 2 JACKSON 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 225 BOLIVAR AVE. BRENDA F. JOHNSON DAUGHTER BALTIMORE, MD. 20b. Plece of Disposition (Name of camelery, crematory or other plece) CROWNSVILLE, V.A. 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 7/10/97 CROWNSVILLE, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PL. BALTO. MD. 21217 21. Signeture of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that caused the shock, or heart feilure. List only one cause on each line. Do not enter the mode of dying, such es cardiec or respiretory errest, Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Metastatic Prostate Cancer 15 months Examiner Due to (or es e consequence ot): Examiner physicien end the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es a consequence of) 50 Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. ete hes been signed by the pege 2 should be deteched 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were eutopsy findings eveilable prior to Completed 24e. Wes en eutopsy performed? completion of cause of deeth? certificate has 1 🗌 Yes 2 No 1 ☐ Yes 2 ☐ No al or Attending Physician: T s after death. Il Director: After this certificet ed in by the funeral director, p 25. Wes case referred to medical Be 26. Piece ot Deeth (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1) Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, term, street, tactory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide Hospital 24 hours a • Funeral To the Hosp within 24 hou To the Funer completely fil 29e. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) and menner stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person of ted cause of death (Item 23a) (Type, Print) 10 N. Greene St., Baltimore, Maryland 21201

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

MK ORMAN FO		State of Maryland	/ Depart		ealth and M		9	7 21181		
Physician /Medical	Decedent's Neme (First, Middle, Last,     NORMAN  4e. Fecility Neme (If not institution, give	FONSE	CA	46	. City, Town, or Lo		09, 199			
Examiner Funeral Director	UNIVERSITY HOSE  5. Social Security Number 6. Se	PITAL S.T.U.			ALTIMOR If Under 24 Hrs. Hours Min.		Y	9. Birthplece (State or Foreign BALTIMORE, MD.		
vith the Maryland or 28a-f show be notified at Director	10e. State 10b. County MARYLAND	-	Town or Locat	ion				10d. Inside City Limits 1 🂢 Yes 2 🗆 No		
dauth with the		VE.		10f. Zip Code 21223  S Decedent of His	penic Origin? (Spe	ecify Yes or N	USA	Whet Country?		
W Jan	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Yeer or Dates:		V	penic Origin? (Spe , Mexican, Puerto Specify:	Rican, etc.)		ck, White, etc. Y: AFRO. AMERICAN		
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Mental Hyg arked observent, To Be C	LEROY PAGIE				18. Mother's Name AUDREY	FOI	NSECA	ne)		
t and 2 sh Health and om 27 is m	19e. Informent's Name/Relationship (Ty AUDREY FONSECA 20e. Method of Disposition	MOTHER 20b. Plac	1111 V	N. MOSHE			IMORE, M	Stete, Zip Code)  ARYLAND 21217 City or Town, Stete		
permit. Pages 1 a Department of He Important: If florm any injury or othe once.	1 ABurial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)  21. Signature of Funeral Sergice Licens	NEW	CATHED	ony or other piece RAL CEME ame and Address	TERY 7		BALTIMO	RE, MARYLAND		
Depa Depa Impo any is	21. Signature of Funeral Service Licensee  22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME, P.A.  1300 EUTAW PLACE, BALTIMORE, MARYLAI  23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest,									
Physician /Medicai Examiner		Muliple Due to (or e						Intervel Between Onset and Death		
be axecuted sicien and burial-transit	Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying	Due to (or e	s e consequer	nce of):						
ieeth certificate be attanding physicie d for use as the bu	Ceuse (Diseese or Injury thet initiated events resulting in death) Last	Due to (or as	s a consequen	nce of):						
d by the setached	Part II. Other eignificant conditions cor	atributing to death but not resulti	esulting in the underlying ceuse given in Pert I.  23b. Did tobacco use contribute to the							
The law requires ate has been sign page 2 should be Completed b	24a. Wes en eutopsy performed?									
ysiclan: The law uis certificate has I director, paga 2 To Be Compl	25. Wes cese referred to medical exeminer?	Jacobal.			26. Plece of Deat		ryes 2□ No one)	15 Yes 2□ No		
hys ald	1 XYes 2 No  27. Manner of Deeth 1 Neturel 5 Pending 2 Accident investigation		Bb. Time of Injury	28c. Injury Work	4 □ Nursing Ho		idence 6 Oth how injury occur ext Sh			
ital or Attending Purs after deeth. ral Director: After tilled in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street,	, factory, office			(Street end Numb own, Stete) Penngy(	per or Rurel Route Number,		
To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	(Check only 2 Medical Examinations)	elclan: To the best of my knowle ner: On the besls of examinetion end menner stated.		tigetion, In my opi	nion, deeth occurr		, dete end place,	end due to the ceuse(s)		
D S S S S S S S S S S S S S S S S S S S	29b. Signature and title of certifier	W 12		O.C.N				09, 1997		

State Registrar

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

W. A. R. Ruck 111 Per 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

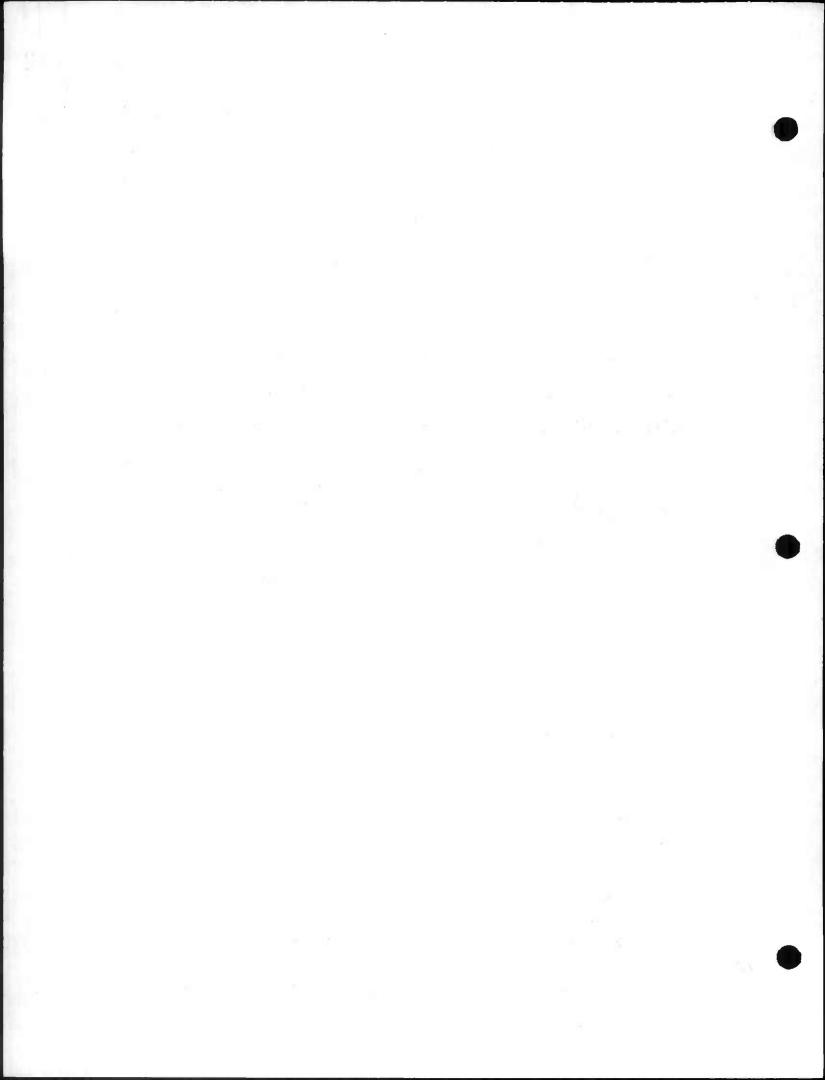
97 21182

					Cei	tificate o	f Death		Reg. No.	- 1	41102
1.17		1. Decedent's Neme (First, Middle,	Last)					2. Date of D	eeth	Van	3. Time of Deeth
Physic /Med		WILLIAM FLO	YD GILBER	$\mathbf{T}$				July	Dey	1997	1:10 P.M
Exami		4e. Fecility Neme (If not institution, p	give street end number	7)			4b. City, Town	n, or Location of Dee	th 4c. County	of Deeth	
		Greater Baltimo	re Medical	Center	r		Tow	son	В	altin	nore
Funeral				ge (In yrs. les		If Under 1 Ye	ar If Under 24				place (Stete or Foreign
Director		167-09-8660	11 M 2□ F	86	Yrs.			Nov. 9	, 1910		nsylvinia
p		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation				1	Od. Inside City Limits
daryia f show ed at	5	Maryland N/A			altim						1 ☑ Yes 2 ☐ No
with the Maryia a or 28a-f show be notified at	Director	10e. Street end Number		100	al L 111.	10f. Zip Code			10g. Citizen of	What Cour	71
with a or		218 E. Lake Av	enuo				1212			S.A.	my r
	Funeral	11. Maritel Status	12. Was Deceden	t Ever in U.S.	13. \			n? (Specify Yes or N			can Indien,
HVB	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces  1 ☐ Yes 2 ☑  If Yes, Give  Yeer or Dates:	No		Yes, specify C I□Yes 2177N		n? (Specify Yes or N Puerto Rican, etc.)		<sub>ok, White,</sub> y: Whit	
7	bed	15. Decedent's	Education	1	6a. Deced	lent's Usual Occ	cupation		16b. Kind of B	usiness/In	dustry
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22 Maria	50	12 years			Gener	al Clai	m Agent		Railr	oad	
D HE HOLD	Be	17. Father's Name (First, Middle, La	est)				18. Mother's	s Name (First, Middle	e, Maiden Suman	ne)	
farylan 2 should be and Mental is manked o	2	Lee Wolsley G	ilbert				Mart	ha Mil	ligan		
and and and and and and and and and and		19a. Informent's Name/Relationship						or Rural Route Numi			Code)
other tr		William F. Gilbe	rt (son)				ter Rd.		Ohio 43		
0 8555		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State	3		sition (Neme of netory or other p		Date	20c. Location	- City or To	wn, Stete
altim nit. Pa antmon ortant: injury 8.		4 Donetion 5 □Other (Spe		Wood		Cemeter		7-15-97	Woodla	wn, l	Maryland
Baltim pemit. Pa Departmen Important: any injury once.		21. Signeture of Funeral Service Lic	censee			. Name end Add	dress of Fecility Wiedefe	1d Home			
- 502 60	L	Leone	Genane		65	00 York	Road	Baltimore		nd 21	212
Physician /Medical Examiner	10	23a. Pert1. Enter the disease or co shock, or heart failure. List or Immediate Ceuse (Final disease or condition resulting in deeth)	е	frs.	unor	eis.		Kemboses		1	Intervel Between Onset end Death
I Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	n/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Undertying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest	c	Due to (or es	s e conseq	uence of):					
IS, P.O. BOX res that the death ce signed by the attendii	Physician/	Pert II. Other significant conditions	contributing to death	but not resultin	na In the u	nderivina ceuse	given in Part I.	23b. Dio	l tobacco use co	ntribute te	o the ceuee of deeth?
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ecord aw require ts been sign	Completed		9/11/2					24a. We	s en eutopsy formed?	ev	ere eutopsy findings reliable prior to empletion of ceuse deeth?
The law rate has page 2:	ЮЩ							1 🗆	Yes 2 No	1[	□Yes 2□No
Vital I	Be	25. Wes case referred to medical exeminer?					26. Plece o	of Death (Check only	one)	1.	
ysicia nysicia nis cert	Tol	1 ☐ Yes 2 No	Hospital: 1 Nopat	ient 2□ER	/Outpatien	t 3 DOA	Other: 4 🗆 Nurs	ing Home 5 ☐ Res	sidence 6 🗆 Oth	ner (Specif	ý)
Division of Vital Records, or Attending Physician: The law requires the after cleath.  Director: After this certificate has been signed in by the funeral director, page 2 should be or a fin by the funeral director.	Certification:	27. Menner of Death  Taturel 5 Pending 2 Accident investigat 3 Suicide 6 Could not	be		b. Time of Injury		Yes 2 N	0	how injury occur		
Division To the Hospital or Attention Within 24 hours after deatl To the Funeral Director: completely filled in by the	Certifi	4 Homicide determine	ad 286. Place of in	njury - At home rtc. <i>(Specify)</i>	e, farm, str	eet, factory, office	×8		(Street end Numl own, State)	ber or Hurs	If Houle Number,
he Hoap in 24 hoi he Funei pletely fi	edicai	29a. Certifier   CertifyIng   Check only one	Physicien: To the best aminer: On the basis of and menner s	of examination	dge, deeth end/or inv	occurred et the restigetion, in m	time, dete end y opinion, deeth	place, end due to the occurred et the time	e ceuse(s) end m , dete end placa,	enner es s end due to	teted. o the ceuse(s)
Total within	Σ	29b. Signature and the of pertifier	lodi n	5		29c. Lice	nse number	5 /	29d. Date signe	ed (Month,	_
10		30. Name end eddress of person where Eddie Nak.	· · · · · · · · · · · · · · · · · · ·				ı Valle	ey Rd T.	imonium	1, Mc	21093
C4		31. Date filed (Month. Dev. Year)	32. Regist								

State Registrar

JUL 1 4 1997





State of Maryland / Department of Health and Mental Hygiene

Item26 7-14-97 FilmG749 W.H.Per Doctor Certificate of Death 1. Decedant's Nama (First, Middla, Lest) 2. Data of Death 3. Tima of Death **Physician** Month Yaer Dolores T. Goodson July 4, 1997 3:48 PM /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Daath 4c. County of Death Examiner Johns Hopkins Bayview Medical Ctr. Baltimore City If Under 1 Year If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** Months Days 1□M 200 F 214-26-1241 67 Director June 26,1930 Maryland Usual Rasidance of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits a notified at the Maryla Dundalk 1 Yas all No Maryland Baltimore Director 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Coda 8 dical Examiner must be 21222 United States 4136 Eder Road Herns 23a Funeral Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Dacedant Evar in U,S. Armed Forcas? 14. Race - Amaricen Indian, Black, Whita, atc. 11. Marital Status 72 hours after 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Dates: 1 Nevar Marriad 277 Married ò 5-0020 1 ☐ Yas 2 No Specify: Specify: þ 3 Widowed 4 Divorced "natural". White Completed 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education 16b. Kind of Businass/Industry (Specify only highast grada complated) Elementery/Sacondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Nama (First, Middla, Maiden Surnema) 17. Fathar's Nama (First, Middle, Last) Be Helen Scztinska 2 Stanley Iszkiewicz 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Numbar, City or Town, Steta, Zip Coda) Department of Health a Important: if Item 27 is any injury or other tra 1 and Mr. Clyde M. Goodson/Husband 4136 Eder Road Dundalk, MD Baltimore, 20b. Place of Disposition (Nama of cemetary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ₺ Burial 2 □ Cramation 3 □ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) Stanislaus Cemetery 7/8/1997 Dundalk, Maryland 21. Signature of Fanaral Sarvice Licensee 22. Nama and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, MD 21222 7922 Wise Ave. 23e. Part1. Entar the diseasa, or complications that ceusad tha death. Do not entar tha mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Cardia arrest /Medical Immediata Cause (Final disaasa or condition rasulting in death) Examiner settenni Ondibraden Dusine buriel-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last pue physician esthe Box 68760. Physician/Medical Due to (or as a consequence of) 9SU ò Part II. Other algnificant conditions contributing to death but not rasulting in tha undarlying ceuse givan in Part I. P.O. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Records, ğ 24b. Wera autopsy findings aveilable prior to complation of ceusa of daath? 24a. Was an autopsy performed? Completed peen 1 ☐ Yes 2 ☑ No 1 ☐ Yas 2 ☐ No Division of Vital 25. Was casa rafarred to madical Be 26. Place of Daath (Check only one) Other: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) ٩ 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: 5 Panding investigation 1 Natural 1 Yas 2 No 2 Accidant 3 Suicida 6 Could not be determined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At home, farm, straat, factory, office building, atc. (Specify) 4 Homicida

 Hospital or Attending Physician:
 124 hours efter death.
 Funeral Director: After this certifice letely filled in by the funerel director; completely To the within 2

29a. Cartifian

29b. Signatura and titla of certifiar

State Registrar

Medical

29c. Licensa number D22723

1년 CertifyIng Phyalclan: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Data signed (Month, Day, Year)

amplell

of death (Nem 23a) (Type, Prigt)
Ud WWW WING WALL 21236

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item29D 7-14-97 FilmG749 W.H.Per Doctor

	,	T T T III C T T T N	.n.rer bocc	U r		Ce	rtificate	e of	Death			Reg. No.			
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Physic /Medi		HERMA	N	А			GRA	BO	YES		July	3, 1	997	9:35	a.m
Exami		4e. Fecility Neme	e (If not institution, g		imber)		- ORA		4b. City, To	wn, or Lo	ocation of Deet	h 4c. Cour	nty of Deeth		a · m
Funeral Director		5. Sociel Sacurity 165–12		Sex 1【XM 2□ F	7. Age (In yrs. les 76	st birthday) Yrs.		1 Yaar Days	If Under Hours	24 Hrs. Min.	8. Dete of Bir Month De JAN 2,	th 1921	9. Birthr	place (Stete or I	Foreign
		Usual Residence													
a-f show	tor	10a. State MD	10b. County BALT	TIMORE	10c. City,	Town or Lo	TOWSO	NC					1	Od. Inside City	
r 28	le le	10e. Street end N	Number				10f. Zip (	Code				10g. Citizen o	of Whet Cour	ntry?	
23a c	a D	108 KE	NILWORTH	PARK DR	.,APT. 2	<b>-</b> A				21204	4	US	SA		
r heelth end Mentel Hyglene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examinar meat be notified at	by Funeral Director		erried 2 Marrled	Armed Fo	ve		Was Decede If Yes, specif		lispanic Orl en, Maxicar Specify:		ecify Yes or No Ricen, atc.)	14. R B	ace - Amaric lack, White, city: WH		
atura De E	9		15. Decedent's E	Education		16a. Dece	dent's Usuel	Occup	ation			16b. Kind of	Business/In	dustry	
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ked i	To B	JACOE	3		G	RABOY	ES		FR.	IEDA	AX	ELROD			
ith and Mantal Hyglane. 27 is marked other that r traumatic event, in a		19e. Informant's SANDRA	Neme/Reletionship A GLASSNE	(Type, Print) ER (DAUG	.)	19b. Mailii 304	ng Address ( HIGH N	Street MEAI	end Numbe	or or Run	al Route Numb	er, City or Tow STOWN ,	m, Stete, Zip MD 2	Code) 1136	
Heelth tem 27 i		20e. Method of D	isposition		20b. Pled	ce of Dispo	sition (Neme	e of			Date	20c. Location	n - City or To	wn. Stete	-
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or L	Physician	Part II. Other eigr	nificant conditions	contributing to de	eath but not resulti	ng In the u	nderlying ceu	ısa giv	en in Pert I		23b. Dld	tobacco use o	ontribute to	the cause of c	death'
igned by the e be deteched f	by Phy										10	Yes 2□ No	3 □ Prol	pably 4 Un	nknow
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peg	ပ္ပို										10	ras 20 No	10	Yes 2□ No	0
s certificate director, pe	Be	25. Wes cese reference?	erred to medicel						26. Place	of Deeth	(Check only o	ne)			
this crail dire	P P	1  Yes 2 1	No.		·	VOutpetien			4 LI Nu	rsing Ho	me 5 Resid	dence 6 0	ther (Specify	HOSP	TC
After	Certification:	27. Menner of Dec 1 Neturel 2 Accident	5 Pending investigation	n	of Injury th, Dey Year)	3b. Time of Injury	M 280	injun Work	ret ∢? Yes 2∐I		28d. Describe I	now injury occi	urred		
	ertific	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	286. Piece	of Injury - At home ng, etc. (Specify)	e, farm, str	eet, fectory, o	office			28f. Locetion (S City or Tox		nber or Rure	l Route Number	r,
To the Funeral Direct	edicai (	29a. Certifier (Check only one)	15 Certifying Pl 2 Medical Exam	nysician: To the miner: On the ba and menr	best of my knowle	dge, deeth	occurred et restigetion, in	the tim	e, date and olnion, deet	d plece, e	end due to the	ceuse(s) end n	nenner es st	eted. the ceuse(s)	
To the comple	Me	29b. Signature ap	d title of certifier	11	oi stateu.	, ,	29c. I	License	number			29d. Dete sign	ad (Month.)	Day Year)	
0		1h	5/	5/		کر		0:	332	2/		July 3,		,,,,,,,	
		30. Name and add	tress of penylon who	completed caus	e of death (Nem 23	a) (Type, I	Print)								
		DR. SHI	RLEY THOM	PSON-RIC	CHARDS 2	2300 1	DULANE	Y V	ALLEY	RD.	TIMON	NIUM, M	D 2109	93	
Sta Registr	te	31. Dete filed (Mo	1 4 1997	4	egistrar's Signetur	Banda B	2_								
negisti	ar		T T 1001		- 1-10 (1000) a-1	- land									

ne a n a esse i William e The state of the s

State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death

Physician	
/Medical	
Examiner	

**Funeral** 

Director

Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

cata has been signed by the attanding physician and page 2 should be datached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

To the Mospital or Attending Physicien: The law requires that the daath certificate be axecuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, paga 2 should be datached for use as the burial-transit

1. Decedent s Items (1 1/3), Widdle, Last	'/		Month Deelli	S. Time of Death			
IRVIN	HAZELL		JULY 09	1997 20:30			
4a. Fecility Neme (If not institution, give	street end number)	4b. City, Town, or I	ocation of Death 4c. Cour	nty of Deeth			
THE JOHNS HOPKINS	HOSPITAL	BALTIMORE	CITY				
5. Social Security Number 6. Se 214-64-8069 11	7. Age (In yrs. last birthday) If U	nder 1 Year   If Under 24 Hrs. https://dx.dec.pub.com/dx.dec.pub.c	8. Date of Birth Month, Day, Year) 55 NOV, 2, 1755	9. Birthplece (State or Foreign Pountry)  Nary and			
10a. State , 10b. County	10c. City, Town or Location			10d. Inside City Limits			
Maryland N/	4 Baltim	ore	40-00:	1 Yes 2□No			
2 C 1	la to Ct	Zip Code	10g. Citizen o	of Whet Country?			
11. Maritel Status	12. Was Decedent Ever in U.S. 13. Wes D	acadent of Hispanic Origin? (S	pacifu Vas or No. 14 B	ace - Americen Indian,			
1 Never Married 2 Married	Armed Forces? If Yes,	ecedent of Hispenic Origin? (S specify Cuban, Mexican, Puert	o Rican, etc.) B	lack, White, etc.			
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give '	es 20 No Specify:	pb-60	rican American			
15. Decedent's Edu (Specify only highest great	de completed) (Give kind o	Usuel Occupetion  f work done during most of work  OT, use retired)	king 16b. Kind of	Business/Industry			
Elementary/Secondary (0-12)	College (1-4or 5+)	Marko	r Roll	City Horth Dent			
17. Father's Name (First, Middle, Last)	11	18. Mother's Nan	ne (First, Middle, Meiden Sume	emp)			
Richard	Hazell	Luci	Ille Wi	lliams			
19a. Informent's Name/Relationship (T)	ype, Print) (Sister) 19b. Meiling Add	Iress (Street end Number or Ru	CL Apt. D. L	m, Stete, Zip Code)			
20a. Method of Disposition	20b. Plece of Disposition	(Name of	Date 20c Location	n - City or Town, Stete			
1 Buriel 2 Cremetion 3 F 4 Donetion 5 Other (Specify)	Removal from State cametery, cremetory	or other place)	7/16/97 Lans	downe, Md.			
21. Signature of Funeral Service Libers	190 P P 1 1 5056	e and Address of Facility	s. Funeral.	Home			
23a. Part 1. Anter the displays or compl	lications that caused the death. Do not enter the	22 W. North	Ave. Balt	o, Md. 2/2/6 Approximete			
shock or heart failure. List only o	lications that caused the death. Do not enter the ne ceuse on each line.	mode of dying, sour es bardiac	or respiretory errest,	Intervel Between Onset end Death			
Immediate Cause (Finel	Novardia Pneu	monia		2. 21			
disease or condition resulting in death)	e. Due to (or es e consequence			months			
		07-1		3 months 5 years 2 weeks			
Sequentially list conditions,	b. Due to (or es e consequence			Jyans			
if eny, leading to immediate ceuse. Enter Underlying	Thrombocytope	nia		2 weeks			
Cause (Disease or Injury thet initieted events resulting in deeth) Lest	C. Due to (or es e consequence	of):					
	d						
	0.						
Part II. Other significant conditione cor	ntributing to death but not resulting in the underlyl	ng ceuse given in Pert I.	23b. Did tobacco use o	contribute to the cause of death?			
CMV RETIN	1713		1 ☐ Yes 2 ☐ No	3 □ Probably 4 ☑ Unknown			
			240 Was an autonou	24b. Were eutopsy findings			
CNS TOXOPLA	AJMUSIS		24e. Wes en eutopsy performed?	eveilable prior to completion of ceuse			
ANEMIA			1 □ Yes 2 🕱 No	of death?			
25. Wes cese referred to medical		26. Place of Dee	th (Check only one)				
examiner?	Hospital: 1 Inpatient 2 ER/Outpetient 3	Other:	ome 5 Residence 8 0	Other (Specify)			
27. Menner of Death  1 X Natural 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury et Work? 1 □ Yes 2 □ No	28d. Describe how injury occ	urred			
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, fac building, etc. (Specify)		28f. Location (Street end Nun City or Town, Stete)	mber or Rural Route Number,			
29a. Certifier 1X Certifying Physic (Check only one)	sician: To the best of my knowledge, death occur iner: On the basis of examination end/or investiga and manner stated.	red et the time, date end plece tion, in my opinion, deeth occur	, end due to the ceuse(s) end r rred et the time, dete end place	menner es steted. e, end due to the ceuse(s)			
29b. Signeture and title of certifier		29c. License number	29d. Date sign	ned (Month, Day, Year)			
> Manuel &		REST 000 July 07, 1997					
, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,	02207				

State Registrar

MANISH

31. Dete filed (Month, Day, Year)
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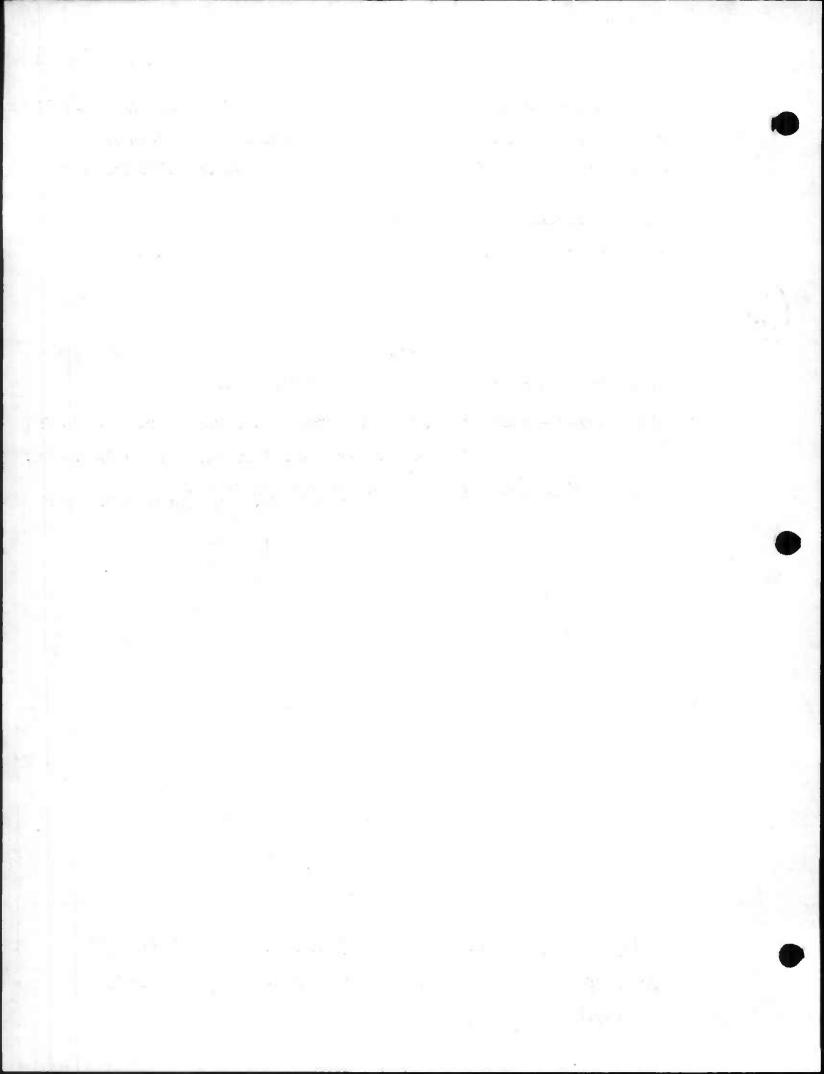
HUSPITAL

TOWER 110

BALTIMORE, MO

					Maryland /		nent of I cate of		nd Mental Hy	rgiene 9	7 2	1186
	Physic /Medi		1. Decedent's Name (First, Middle, Lo Mary Alice	Hoover					2. Date of De Month	_	1997	3. Time of Death 10:00 a
	Exami	ner	4a. Facility Name (If not institution, gi 4616 Water Ta		er)			4b. City, Town Manche	n, or Location of Deel ester		of Deeth	
	Funeral Director		5. Social Security Number 6. 215–26–8868  Usual Residence of Decadent		Age (In yrs. last		Under 1 Year inths Days		Min. Septe of Bi	11, 1930	9. Birthpla Mar	yland
	vith the Maryland or 28a-f show be notified at	ctor	10a. State 10b. County Maryland Carro	011		own or Location					100	d. Inside City Limits
	3a or 28 at be no	i Director	10e. Street and Number 4616 Water	Tank Rd.	)	10	of. Zip Code 211	02		10g. Citizen of V		y?
6		by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decede Armed Force 1  Yes 2[ If Yes, Give Year or Date	s-7- ⊒ANo		Decedent of F , specify Cub 'es 2 No		n? (Specify Yes or No Puerto Rican, etc.)	5- 14. Race Blace Specify	a - American ck, White, et	
212/6-0		Completed	15. Decadent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4c		6a. Decedent's (Give kind life. DO N	of work done OT use retire	pation during most o d)	f working	16b. Kind of Bu	usiness/Indu	
Maryland 2	2 should be filled and Mental Hyg is merked other sumstic event, I	To Be Co	17. Father's Name (First, Middle, Last Henry Houck	•		2000			Name (First, Middle Snyder			5011001
Baltimore, Mar	ges 1 and t of Health if flem 27 or other tr		19a. Informant's Name/Relationship Stanley Hoover  20a. Method of Disposition 1	- husba	and 4	.616 Wa	ater (Name of y or other pla	Tank I	Rd. Manc. Date July 14	hester, 20c. Location -	Md •	21102 m, State
Balti	permit. Pa Departmen Important: any injury socs.		21. Signature of Funeral Service Lice		<b>U</b> X	22. Nar	ne end Addre	ess of Facility	cal Chap			
Box 68760,	beath certificate be executed was attending physician and attending physician and I for use as the burial-transit	Physician/Medical Examiner	23a. Part 1. Enter the disease, or conshock, or heart failure. List only  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	a  b  d	Due to (or as	a consequence a consequence a consequence	egal	y	irdiac or respiratory a	irrest,	1 10	Approximate niterval Between Onset and Death
P.0.	The law requires that the death certificate has been signed by the attending I paga 2 should be datached for use as		Part II. Other significant conditions of	eontributing to death	n but not resulting	g in the underly	ring cause giv	ven In Part I.  Mutz	al 10	Yes 2 1000	3 Proba	the cause of death?  ably 4 Unknown  e eutopsy findings lable prior to
al Reco		Completed by	m	rugge	ren	y			10		com	pletion of cause eath?
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner?  1	e 28e. Place of I		o. Time of Injury		ner: 4 🗆 Nursi	28d. Describe	dence 6 Other	red	Route Number,
	Hospital 24 hours a Funeral Dietely filled	edicai Ce	29a. Certifier (Check only one)  Certifying Ph	ysician: To the bes	of examination e	ge, death occu end/or Investig	rred at the tir ation, In my o	ne, date end p pinion, death	place, and due to the occurred et the time,	cause(s) and ma date and placa, e	nner as stat	ed. he cause(s)
	To the within To the compl	Me	29b. Signature and title of cartifler  W/J/7 or	ard 1	up	\	29c. Licens	o and one of the contract of t	86	29d. Date signed	1 (Month, De	ıy, Yoar) 7
	Sta Registr		30. Name end eddress of person who 31. Date filed (Month, Day, Year)	rd MD	death (Item 23a 3 2 2 strar's Signature	3) (Type, Print)	NSt	M	ANches	terA	1/2/	102

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Daeth 3. Tima of Death TOHNSON ul 4a. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death ARYLANI BALTIMORE C17 If Under 24 Hrs. 8. 5. Social Sacurity Number 212-20-679.
Usual Residence of Decedent If Undar 1 Yaar 6. Sax 1 M 2 □ F lest birthdey) Birthplaca (State or Foreign Country) -6795 Deys 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Evar In U,S. Armed Forces? 1 (A)Yas 2 □ No If Yes, Giva Yaar or Dates: 11. Maritel Status Was Dacedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) Rece - American Indian, Black, White, etc. 1 Naver Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced American itrican 16e. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery (Secondary (0-12) College (1-4or 5+) 10 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nema (First, Middle, Meiden Surpeme) ster 19b. Meiling Address (Street and Number or Ryral Route Number, City of Town 6810 eamond 20e. Method of Disposition 20b. Place of Disposition (Ne cemetery, cremetory or 1 ☐ Buriel 2 ☑ Cremetion 3 Ramovai from State 4 ☐ Donetion 5 ☐ Other (Specify) son 21. Signature of Funerei Sarvice Licensi 22. Name and Address of Fa 050 Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiretory arrest, or heart fulfure. List only one cause on each line. Approximata Intervei Between Onsat end Daath . Palmonak Immediate Causa (Final disaase or condition resulting in deeth) ciency Syndrome Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Couse (Diseese or Injury that initiated evants resulting in death) Lest Due to (or es a consequence of) Dua to (or as e consequance of): 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were eutopsy findings evaileble prior to 24a. Wes en eutopsy performad? completion of cause of death? 1 Tyes 2 1 No 1 ☐ Yas 2 ☐ No

**Physician** /Medical Examiner

ettending physician end for use es the buriel-transit

isigned by the e

certificate has been si irector, page 2 should

After

within 24 hours efter death.

To the Funeral Director: All
Completely filled in by the fu

Records, P.O. Box 68760

Division of Vital

To the Hospital or Attending Physicien: within 24 hours efter death.

**Physician** 

/Medical

**Examiner** 

10a. Steta

Director

Funeral

þ

Completed

Be ပ

**Funeral** 

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f ehow injury or other traumatic event, the Modical Examinal must be notified at

death with the Meryland

filed within 72 hours efter Hyglene.

permit. Peges 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", eny injury or other traumatic avant.

Baltimore, Maryland 21215-0020

Physician/Medical þ Be Completed 25. Wes cese referred to medical Medical Certification: To

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Pert I.

26. Plece of Death (Check only one) 2 ER/Outpetient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

8929

3 Suicide 8 Could not be determined 28e. Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

ecilia Guma,

1 | Inpatient

Location (Street end Number or Rural Route Number, City or Town, Steta)

29b. Signature and title of certifier

2 No

5 Pending

Investigation

25

1 Yes

27. Mennef of Deeth

1 Neturel

29e. Certifier

2 Accident

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

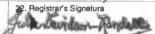
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) end menner steted. 29c. License number 29d. Dete signed (Month, Dey, Year)

30. Neme end eddress erson who completed cause of deeth (Item 23a) (Type, Print)

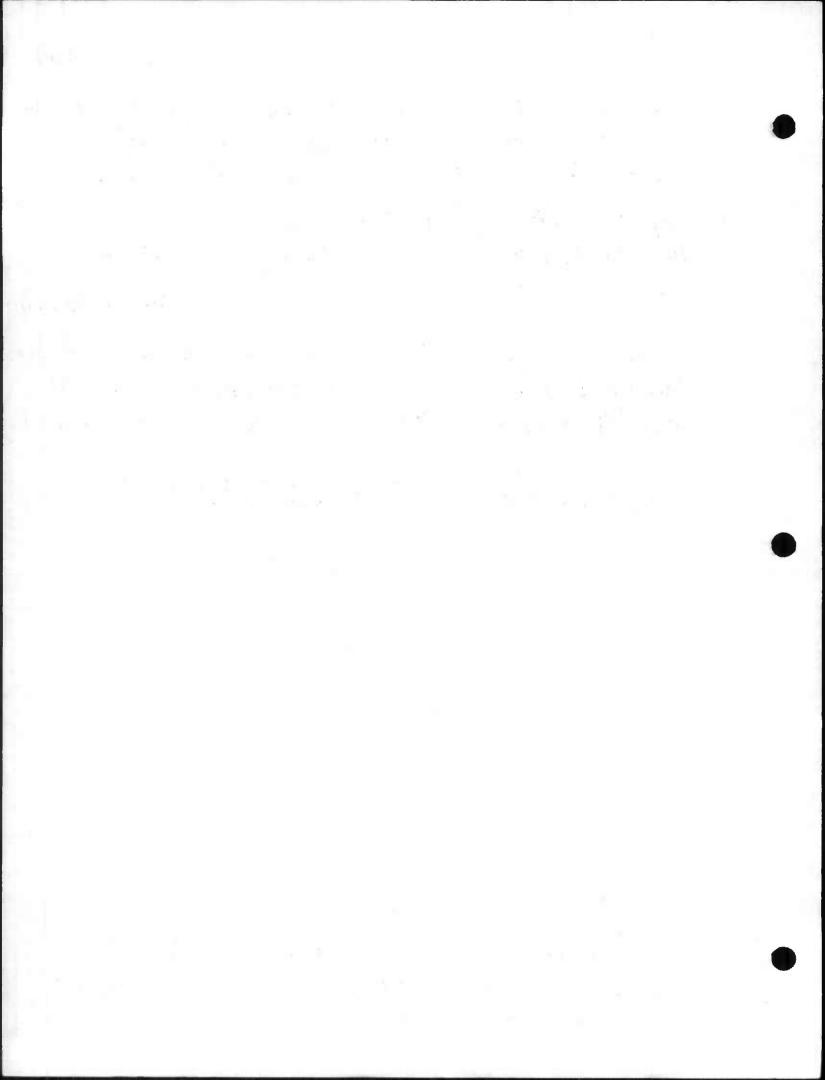
Maryland General

State Registrar 31. Date filed (Month, Day, Year)

Lourd



M.L



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death **Physician** Month John Jackson duly 1997 9:10 AM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Bultimore Smei Hospital, 2401 W. Belvedere Ave (Buttimore City If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 6. Sex 100 M 2□ F 8. Date of Birth 5. Sociel Security Number Birthplece (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 220-05-761 Usuel Residence of Decedent Director 1.00 permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mantel Hygiane. Important: If Item 27 is marked other than "netural", or items 23e or 28e4 show any injury or other transmitter own, I'm Madical Exertinal Partmetter notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Nedical Examinar must be notified at 1 Yes 2 □ No Director 'lary land imore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3616 Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1□Yes 2 No Specify. þ Specify: 3 Widowed 4 □ Divorced Slac Completed 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Callege (1-4or 5+) 101 17. Father's Name (First, Middle, Last) Be MAKNOWY nowr 19a. Informent's Name/Relationship (Type, Print (Care provider) 19b. Mailing Address (Street end Number or Rurel Royte Number, City or Town, Stete, Zip Code) Balto, Md. 212/6 20c. Location , City or Town, State 616 rairulew 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition / Date 1 ☐ Buriel 2 Cremation 3 ☐ Removal from State 4 Donetion 5 ☐ Other (Specify) eenmou 21. Signetare of Funeral Service Licensee 22. Name end Address of Fecility Joseph uneral Hom W. North AUR. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Death Physician /Medical Immediete Cause (Final . Pneumonia secondary to Staph. Aureus disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner Bucteremia the attanding physician and ched for usa as tha buriel-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Lest Due to (or es e consequence of) Physician/Medical Due to (or as e consequence of) signed by the atta d be dateched for Pert II. Other eignificent conditione contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown cerebrovascular accident, sacral decubition 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? ulcer, poor nutritional status 2 No Aftar this cartificate 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this cartifice complately filled in by the funeral diractor; a 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 patient 2 ER/Outpetient 3 DOA 27. Manner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be determined Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 12 Sertifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. Medical 2 Medicel Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and menner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) AS2402321-AA9516 Luly 9, 1997 2

who completed cause of death (Item 23e) (Type, Print)

mo 32 Registrer's Signeture

Since Hospital . 2401 w. Belveders fre mozizis

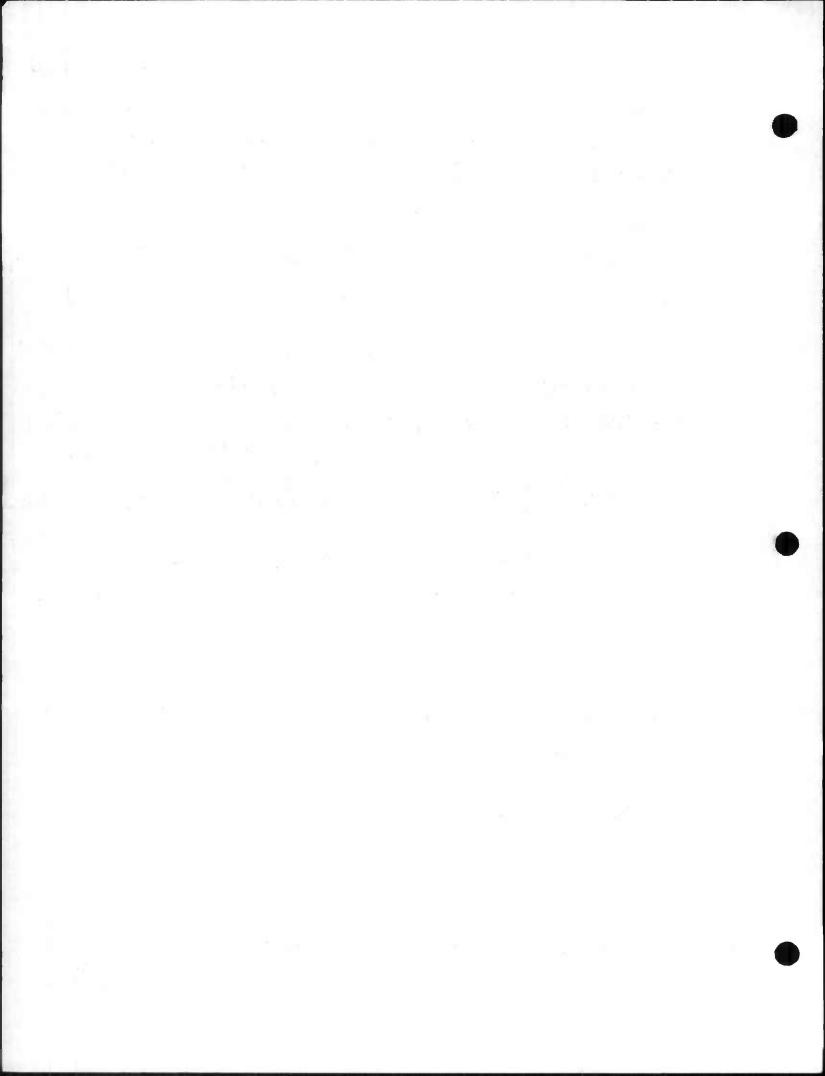
Anna Abraham,
Date filed (Month, Dey, Yeer)

JUL 1 4 1997

Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



State of Maryland / Department of Health and Mental Hygiene

Items 28a-28f 7-14-97 FilmG749 W.H. Per Doctor Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death 920 **Physician** Month ACKSON 6 EDWARD /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** OF MANYLAND HOSPITAL BALTIMORE UNIVERSITY If Under 1 Year Months Deys 5. Sociel Security Number If Under 24 Hrs. Hours Min. 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 1 2 F 214 44 2048 61 Yrs Director unknown Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits unknown 28a-f show Examiner must be notified at Director unknown unknown unknown the 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò Items 23a unknown unknown U.S.A. Funeral 12. Wes Decedent Ever in U.S.
Armed Forces? unknown
1 | Yes | 2 | No
If Yes, Give
Year or Dates: 11. Marital Status 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. should be filed within 72 hours after ond Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 € No Specify: by Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed event, the Medical 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retirad) 15. Decadent's Education ify only highest grade completed) 16b. Kind of Business/Industry (Specify Elementary/Secondery (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) permit. Pages 1 and 2 should be to Department of Health and Mental Important: If Item 27 is marked of any injury or other traumatic eve unknown Othelia Turner 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Corine Hack/aunt 5318 Beauford Street, Baltimore, Maryland 20b. Piece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donetion 5 ☑ Other (Specify) in state 21. Signeture of Funerei Servica Licansee Ronald S. Wade 0/16/97 22. Name end Address of Fecility Director State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

23a. Parti. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, stylick, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Cause (Finai Cardines nivertey pulled disease or condition resulting in deeth) Examiner Physician/Medical Examiner and of unic The law requires that the death certificate be assouted Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequença of): P.O. Box 68760, the Due to (or as e consequence of): SB ate has been signed by the a paga 2 should be datached t Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hencito a Uldar Records, þ Completed 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? SRV 20 po 1 ☐ Yes 2 €No certificate 1 ☐ Yes 2 ☑ No of Vital or Attending Physician: Be 25. Was case referred to medical 26. Pleca of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Date of Injury (Month, Day Year) 27. Megner of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 1 Naturel 5 Pending investigation 1 Yes 2₩No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours aff To the Funerel Di completaly filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end menner steted. Medical 29e. Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) D0050742 Ottega, W 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) U MUNS DIVISION U LUIS M. ORTEGA 31. Dete filed (Month, Day, Year) 32 Begistrar's Signeture State

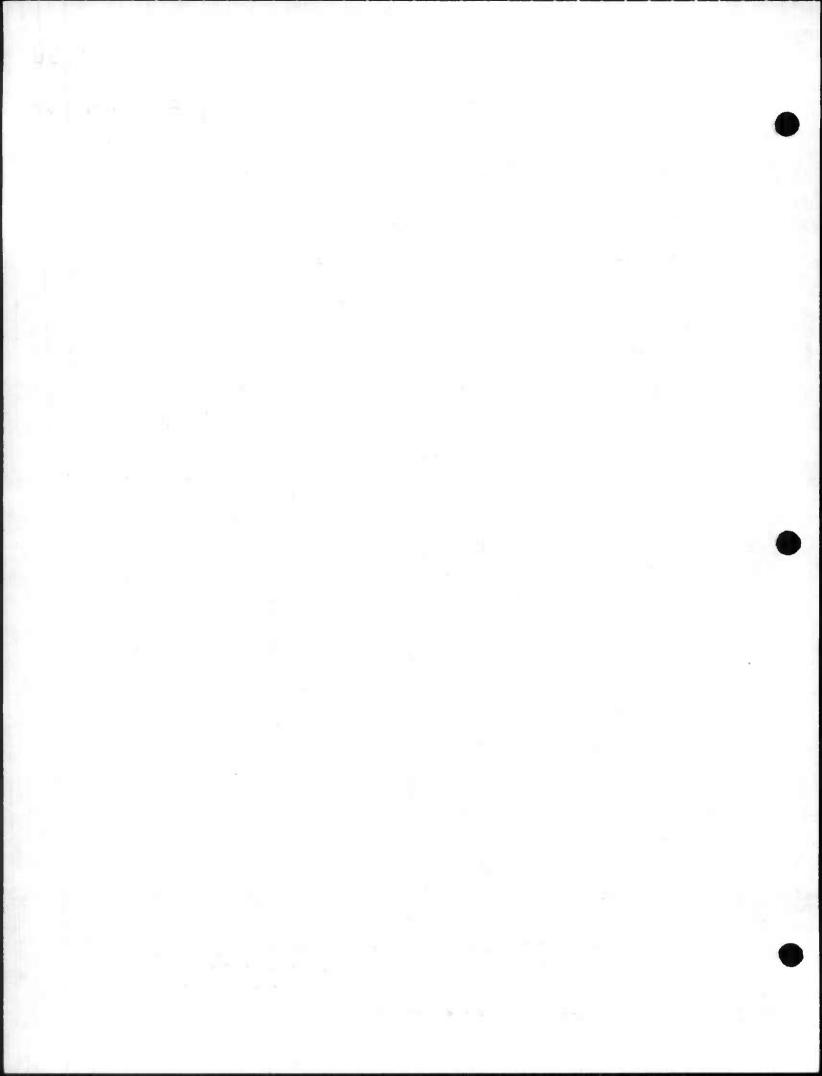
**DHMH 16 Rev 6/95** 

Registrar

1 4 1997

State of Maryland / Department of Health and Mental Hygiene 97 21190

						Cei	rtificate of	Death		R	eg. No.		
п			1. Decedent's Neme (First, Middle,	Last)					2	2. Dete of Deat			3. Time of Death
и	Physic		ARLINE	3.	KIDD				-	Month	8 (9	797	11:25A
	/Medi Exami		4e. Fecility Neme (If not institution, g	rive street end numb	ber)			4b. City, Town		-010	4c. County		11.2011
7	Exam	Hei	Mercy Stella			30		Balt			To: County		
Ŀ							If Under 1 Year					NA	
	Funeral		216-05-0221	1□M 2□XF	. Age (In yrs. la 86	Yrs.	Months Days		Min.	Date of Birth (Month, Dey,	Yeer)	9. Birthi	place (State or Foreign ntry) VA
	Director				00	TIS.				06-01-	11		VA
	D >		Usual Residence of Decedent  10a. Stete 10b. County		10. 00	T							
	show	<u>_</u>				, Town or Lo							10d. Inside City Limits
	W J	cto	Md NA		Ba	altim	ore						1 Yes 2 No
	# 28	Director	10e. Street end Number				10f. Zip Code			1	0g. Citizen of \	Whet Cou	ntry?
	3a c		501 East Pres	ton Str	eet Ar	526	23.20	12			TTOR		
	J within 72 hours after death with the Maryland jiana. r than "natural", or items 23a or 28a-f show than "mattre notified at the Madical Exercitor must be notified at	Funeral	11. Merital Status	12. Was Decede			2120 Was Decedent of		n? (Sneci	fy Yes or No-	USA 14 Bac	e - Ameri	can Indian,
	iter in	ş	1 ☐ Never Married 2 ☐ Married	Armed Force	es?		If Yes, specify Cut	oan, Mexican, I	Puerto Ri	can, etc.)		ck, White,	
N	s at	by	3 ₩idowed 4 Divorced	if Yes, Give			1 □ Yes 2√DXNo	Specify:			Specify	/:	
3	urai	<u>8</u>	A	Yeer or Date	BS:							Bla	
0700-61717	72 net	Completed	15. Decedent's (Specify only highest of	Education trade completed)		16a. Deced (Give	dent's Usuel Occu kind of work done DO NOT use retire	pation during most o	f working		16b. Kind of B	usiness/In	ndustry
V	within ana. than 'r	idu	Elementary/Secondary (0-12)	College (1-4	or 5+)			ed)					_
	filed withi Hygiana. rther than	Ö	/th Grade	NA		Dom	estic				vario	us t	rades
3	0 = 0 5	Be	17. Fether's Neme (First, Middle, La	st)				18. Mother's	Neme (	First, Middle, M	/aiden Sumem	10)	
2		To E	Augustus	S	essoms	5		Reb	ecca	a		Robe	rts
Maryland	음말투투	-	19e. Informent's Name/Reletionship	(Type, Print)		19b. Mailin	ng Address (Stree		-				
M	(2) 中里 美												0000)
ů	os 1 and 2 of Health a Item 27 is other tree		Margaret Moor 20a. Method of Disposition	e	20h Ble		Hill S	creet		- 1	C 295		0
5	or of h		1√2 Burial 2 ☐ Cremation 3	☐Removal from Sta	Cel	metery, cren	netory or other ple		!	-	20c. Location -		
allillore,	Pant:		4 Donetion 5 □Other (Spec		Ark	outus	Mem. F	k. Ce	m C	07-12-	97 Ar	outu	ıs, Md.
	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other in		21. Signature of Funeral Service Lic	ensee /		22	. Name end Addr	ess of Fecility	Bal	ltimor	e, Ma	rvla	nd 21202
Š	Depa impo any i		110 mina	()_d		FAT	M O MA	ach DII				-	
	_	-	JUVIONE	1 NA			M.C.MAr					Ave	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	y ene ceuse on eec	sed the death. h line.	Do not ente	er the mode of dy	ng, such es ca	irdiac or r	respiratory erre	est,	i i	Approximete Intervel Between
	Physician											į	Onset end Death
	/Medical		Immediate Cause (Final disease or condition	MET	ASTATI	c i	LUNG C	CANDE	7				~ 8 mos
	Examiner		resulting in death)	a		as e conseq							
		ě				20.2 - 1120							
	utad d ansi	Examiner	Sequentially list and divisor	b. —	Due to for	es a conseq	ueneo of).						
2	exec n en iel-tr	Exa	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying		D00 10 (01	es a conseq	delice oi).						
00100	cartificate be executed identificate by signification and itse as the bundel-transit	100	Ceuse (Disease or Injury thet initieted events	c									
	phys tha	edical	resulting in deeth) Last		Due to (or e	es e consequ	uence of):					i	
<	cartificanding plants as t	/Me		l d									
	- 5 -		_	<u> </u>									
	ha daeth tha atter thed for u	sic	Pert II. Other eignificant conditione	contributing to deat	h but not result	ting in the ur	nderlying cause gi	ven in Pert I.		23b. Dld to	bacco use coi	ntribute t	o the cause of death?
	± 50 €	Physiclar		-						NOV	s 2 No	3□ Pro	bably 4 Unknow
		by F									10110	0	
(Spinos)	requiras een sign hould be									24a. Wes er	autoney	24h W	ere eutopsy findings
		ete								perform		ev	reilable prior to empletion of cause
	2 8 0	ď										of	deeth?
		Completed								1□ Ye	s No	1[	Yes 2 No
3		0	25. Wes case referred to medical					26 Place of	Deeth //	Check only one	STELLA		
	ysicism: s cartific director,	To B	exeminer?	Hospital:	ationt ODE	D/Outnotion	Oti	hor:					
5	E E		27. Manner of Deeth	28a. Dete of I	atient 2 ☐ E	28b. Time of	1 3LI DOA	4 LI Nursi			nce MOth		W) HOSPICE
	or atta	lon	12 Naturel 5 ☐ Pending	(Month,	Dey Year)	Injury	28c. Inju Wo			u. Describe no	w injury occurr	60	
	Attending F r death. sctor: Aftar by the funer	cat	2 Accident Investigeti 3 Suicide 6 Could not	he				Yes 2 □ No					
	A DO S	#	4 Homicide determine	200. Plece of	Injury - At hometc. (Specify)	ne, ferm, stre	et, factory, office		28f	Location (Str City or Town		er or Rure	el Route Number,
	Hospital or Athend 24 brus affer death Fundral Director: A stay filled in by the f	Certification:											
1			29a. Certifier 1 Certifying P	hysician: To the be	st of my knowl	edge, death	occurred et the ti	me, dete end p	olace, end	d due to the ce	use(s) and me	nner es s	teted.
1	Fera Fera	edical	(Check only 2 Medicat Exa	miner: On the basis and manner	s of examinetic	on and/or Inv	estigation, in my o	pinion, death	occurred	et the time, da	te and place,	and due to	the cause(s)
	with r	M	29b. Signeture end title of certifier				29c. Licens	se number		29	d. Date signed	d (Month.	Day, Year)
1	->-0		37.	men	DARK						11.	9	1997
								40482			mey	1	
			30. Name end eddress of person who		of death (Item 2	23a) (Type, F	Print) 581	0 3E	CALIC	2120			
			FERNANDO U	FERRO	no		3.	200	MD	2,20	6		
	Sta	te	31. Date filed (Month, Day, Year)	32,000	strace Signatu	10 0	-						
	Registr		JUL 1 4 1997	900	a Davidson	n-Admide	AREA.						



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

**Physician** /Medical Examiner

ELEANOR KOLLER

> Eleanor A. Koller

1. Decedent's Name (First, Middle, Last)

JULY

2. Date of Death

3. Time of Death

4e. Fecility Neme (If not institution, give street end number) GOOD SAMARITAN HOSPITAL 4b. City, Town, or Location of Death BALTIMORE

1997 2:09P.M. 4c. County of Death

**Funeral** Director

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Records,

Division of Vital

Hospital or Attending Physician: 24 hours efter death.

5. Social Security Number 1**⊠**M 2□F 213-26-2611

10b. Count

If Under 1 Year 7. Age (In yrs. last birthday) Deys Months Yrs

10f. Zip Code

If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) AUGUST 20, 1928 9. Birthplace (Stete or Foreign Maryland

Usuel Residence of Decedent 10a. State

6527

rector

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Completed

Be 2

the Medical

2 flied within 7 Hygiene. other than "n

permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygies Important: If them 27 is marked other the any Injury or other transmitted.

**Physician** /Medical

**Examiner** 

burial-transit

attending physician for use es the buria

signed by the a

page 2 should Completed

Deen

certificate hes

this funeral

After

To the Hospital or Attendif within 24 hours efter death. To the Funeral Director: A completely filled in by the fo

Examine

Physician/Medical

þ

Be

To

Certification:

N/A

10c. City, Town or Location

10d. Inside City Limits 1X Yes 2 No

Maryland 10e. Street end Number Baltimore

68

10g. Citizen of Whet Country?

Hilltop Avenue

21206 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) United States Race - American Inc Black, White, etc.

1 Never Married 2 Married 3 X Widowed 4 ☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Yeer or Detes:

1 ☐ Yes 2 X No Specify:

Specify: White

15. Decedent's Education (Specify only highest grede completed)

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementery/Secondary (0-12)

College (1-4or 5+)

Registered Nurse

Health Care

17. Father's Name (First, Middle, Last)

Paul W. Sick

Elsie Sophia Schuette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

19a. Informent's Neme/Relationship (Type, Print)

210 Sandhill Road

22. Name end Address of Fecility

Mrs. Pamela Savoie / Daughter

20b. Place of Disposition (Neme of cemetery, cremetory or other place)

Baltimore, MD 21221 20c. Locetion - City or Town, State

18. Mother's Name (First, Middle, Maiden Sumeme)

1 M Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)

Parkwood Cemetery

7/15/97 Baltimore, Maryland

21. Signeture of Funeral Service Licensee

Timothy S. Harman

eonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214

and Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellore. List only one cause on each line.

Due to (or es e consequence of):

Approximete Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Last

Due to (or es a consequence of)

Due to (or as a consequence of)

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was en eutopsy INSPECTION

1 Tyes

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical XXYes 2 □ No

28e. Date of Injury (Month, Day Year) 5 Pending investigation

1 ☐ Inpatient 3 ☐ DOA 28b. Time of

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

3(T)(No

29a. Certifier (Check only

27. Manner of Deeth

2 Accident 3 Suicide

4 Homicide

Waturel

1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) end menner steted.

29b. Signature at nd title of certifie

O.C.M.E.

29c. License number

JULY 12,1997

29d. Date signed (Month, Day, Year)

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

J. Laron Locke M.D.

111 Penn Street, Baltimore, Maryland 21201

26. Place of Death (Check only one)

State Registrar 31. Dete filed (Month, Day, Year) 32. Registrar's Signature JUL 1 4 1997

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					C	ertificate	e of	Death		Reg. No.			
	Physic /Medi		Decedent's Neme (First, Middle, La ELLEN	st)	KRAI	ICK			2. Dete of D	eeth	1997	3. Time of Death  11:05 AM	
1	Exami		4a Fecility Name (If not institution, given Saint Joseph I	e street and number) Medical Ce	nter			4b. City, Town, or			y of Deeth Balti	imore	
	Funeral Director		5. Social Security Number 6. S 076-18-4143 Usuel Residence of Decedent	Sex 7. Age (In	yrs. lest birthda 73 Yrs	Months	1 Year Days	If Under 24 Hrs Hours Min		rth ey, Year) 1924		place (State or Foreign ntry)	
	er deeth with the Maryland Items 23e or 28s-f show	rector	10a. State 10b. County MD. BALTIM 10e. Street end Number		Cocke	Location  YSVILL  10f. Zip (				10g. Citizen of		10d. Inside City Limits 1  Yes 2 No	
	3e or	D	604 KNOLLCres	DRIVE		1024		030		U S		My I	
020	buts after deetl	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Nidowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1  Yes 2 No If Yes, Give Year or Detes:	in U,S. 1	3. Was Decede If Yes, specif		dispenic Origin? (san, Mexican, Puer Specify:	Specify Yes or Note Rican, etc.)	o- 14. Ra Ble Speci			
3	肾科机	eted	15. Decedent's Ed (Specify only highest gre	ducation ade completed)	16e. De	cedent's Usuel ve kind of work	Occup k done	pation during most of wo d)	orking	16b. Kind of E	Business/In	dustry	
É	442	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		OUSEW!		d)		Ham	e		
P	a figure	Be Co	17. Fether's Neme (First, Middle, Last)	)			,	18. Mother's Na	ame (First, Middle, Maiden Sumeme)				
Maryland	2 should be and Montal is marked o	To B	CARMINE D'Ad  19e. Informent's Name/Relationship (	dario Type, Print)	19b. Ma	ailing Address	(Street	Gemre end Number or F		taglia ber, City or Town	n, Stete, Zip	o Code)	
Baltimore, Ma	permit. Pages 1 and 2 should Depertment of Health and Mer Important: if item 27 is marter any injury or other trauments once.		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donetion 5 Other (Specification 2). Signature of Funeral Service Licentees	Removel from State y)	Db. Place of Discemetery, of	position (Nemoremetory or ot)	e of her ple	ess of Facility	Md 21030 own, State , Md .				
	Physician /Medical Examiner		23a. Pert1. Enter the disease, or com shock, or heart failure. List only  Immediate Ceuse (Final disease or condition resulting in death)	plications that caused the one dause on each line.  RESPIRAT(	death. Do not		Charle of dyir	peles Chi	mes 23 ac or respiretory	25 York Ferrest,		Approximate Intervel Between Onset end Deeth MINUTES	
ox 68760,	eath certificete be executed ettending physician end for use es the buriel-transit	in/Medical Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest	CARDIOGEN  Due  ACUTE MYC	to (or es e cons DCARDI to (or es e cons	equence of):  L INF						DAYS DAYS YEARS	
. 8	deat	Physician/	Part II. Other eignificent conditione o	ontributing to death but no	t resulting in the	underlying ca	use giv	ven in Pert I.	23b. Did	tobacco uee co	ontribute t	o the cause of death?	
P.0	thet the death cer ed by the ettendin deteched for use	Phy	PERIPHERAL V	ASCULAR DI	SEASE				109	Yes 2□ No	3□ Pro	bably 4 Unknown	
Records,	aw requires s been sign 2 should be	Completed by	DIABETES							s en eutopsy ormed?	ev	ere eutopsy findings eilable prior to impletion of cause deeth?	
œ =	The ate h	Com							1 🗆	Yes 2 No	1 [	☐ Yes 2 No	
Division of Vital	To the Hospital or Attending Physician: The within 24 hours effer death.  To the Funerel Director: Affer this certificate completely filled in by the funerel director, page	Certification: To Be	25. Was case referred to medical exeminer?  1	28a. Date of Injury (Month, Day Yea	At home, farm,	of 28	Bc. Injur Wor 1 🗆	er: 4 Nursing	28f. Location	idence 6 □Ot how injury occu	rred	fy) el Route Number,	
_	To the Mospital or within 24 hours effe To the Funerel Dir completely filled in	edical Ce	29a. Certifier (Check only one) 1 Certifying Ph	yelclan: To the best of my niner: On the basis of exar end manner stated.	knowledge, de mination end/or	ath occurred el Investigation, I	t the tir	me, date end plec pinion, death occ	e, end due to the urred et the time	cause(s) end m	anner es s , end due t	teted. o the ceuse(s)	
	To the Within To the	Me	29b. Signature end title of certifier		- m	2		e number		29d. Date sign	ed (Month,	Dey, Year)	
)			Richard	L. Lwett	Ticum	_ D 3	18	26		7-10	-7-	7	
	30		30. Name end eddress of person who RICHARD L. LINT	completed cause of deeth	(Item 23a) (Typ 76 2	e, Print) 20 YOR	K F	ROAD, T	OWSON,	MARYLI	AND	21204	
	Sta Registr		31. Dete filed (Month, Pay Year)	Fisher Savidson	ignature N-Adndali	6							

Registrar

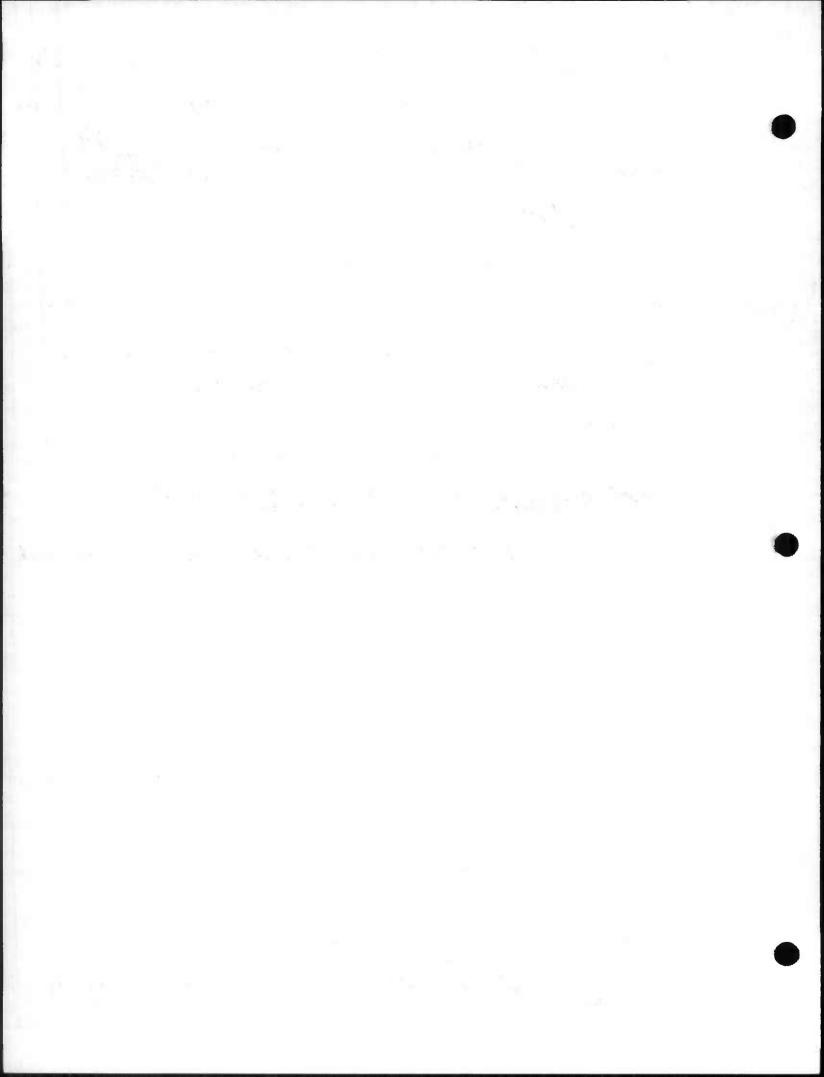
State of Maryland / Department of Health and Mental Hygiene

				Ce	ertificate d	of Death		R	eg. No.		
		1. Decedent's Nama (First, Middle, Las	t)					2. Date of Dea	th		3. Tima of Death
Phys		JOSEPH JOHN L	TNK TP					Month July 1	Day	Year 7	12:45 AM
/Me Exar	dical	4a. Facility Neme (If not institution, giva				4b. City, To	wn, or Loc	ation of Death	4c. Count		12:47 AM
Exal	miei	GREATER BALTIMOR		MTER		TOWS	ON		BALTIN		יצידיותו זרי
-		5. Social Sacurity Number 6. Sa		rs. last birthday	If Under 1 Ya			8 Dete of Birth			
Funer Direct			ZM 2□F	Yrs.	Months Da		Min.	8. Dete of Birth (Month, Day			place (Stete or Foreign atry)
Directi	,,	Usual Rasidance of Decedant	A	8			1	Vov 24,	1918	Penns	sylvania –
-1-		10a. Stete 10b. County	10c.	City, Town or I	.ocation					1	0d. Insida City Limits
100	ō	Maryland N/A		Balti	more Ci	tv					11 Yas 2 □ No
EXX.	Director	10a, Street end Number			10f. Zip Cod	,		1	0g. Citizen of	What Coun	ntrv?
1 180 28	1   5	5012 Greenleaf Ro	hood		,	1210					No.
1	Funeral		12. Was Dacedent Ever i	oll 6 12			inin? /Can	oifu Van as Na		JSA ce - Americ	an Indian
then then the	5	11. Meritei Status	Armed Forces?	10,3.	Was Decedant of If Yas, specify C	Cuban, Mexicar	n, Puerto P	Rican, etc.)		ck, Whita,	
20	by F	1 ☐ Never Marriad 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yas, Give Yaar or Datas:		1 ☐ Yas 2 📆	No Spacify:	:		Spacif	iv: Wh	nite
Maryland 21215-0020 d 2 should be filed within 72 hours at th and Mental Hygiene. T is marked other than "natural", or traumatic event, the Medical Exam				100 Doo	ndantia Hausi Oa	ounation			40h Mind of D		
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10		30. Name and addrass of person who co	omplated cause of daeth (	ltam 23a) (Type		3.00					
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State Registrar

State of Maryland / Department of Health and Mental Hygiene 97 2 1 1 91

					,	Ce	rtificate	of D			Reg. No.	1 6	1194
	Physic	ian	1. Decedent's Nema (First, Mic	ddle, Lest)	Ca1					2. Dete of De	eth Day	Y-er	3. Time of Deeth
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-	Funeral	-	Good Samari  5. Social Security Number	6. Sex		er s. lest birthdey)	If Under 1		Baltimor If Under 24 Hrs.	8. Date of Bir	th =	9 Birthole	ace (State or Foreign
4/1	Director		216-28-8413 Usuel Residence of Decedant	1□ M 2 <b>)XXX</b>		Yrs.	Months	Days	Hours Min.	8. Date of Bir Month, Da Jan 24,	1909	Baltim	ace (State or Foreign ry) Dire, MD
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8	IA V	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ M  3.□ Widowed 4 □ Divorce	arried 1 Yes	22XX		wes becede If Yes, specif	fy Cuben,	oanlc Origin? (Spo Mexican, Puerto Specify:	Rican, etc.)		ce - America ick, White, et fy:	
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Maryland	od be miss	Be C	Adelbert Pla					'		therine		ne)	
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Ĕ	Page int: R		Unial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Othar	n 3 ∐Removel fron <i>(Specify)</i>	n State Ne	w Cath				14	Balto,	MD	
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÷	_	-	23a. Part1. Enter the diseese, shock, or heart feilure. L	or complications thet	ceused the dea	ath. Do not ent	Balto,	MD of dving.	21211 such as cerdiac	or raspiratory a	rast		Approximate Intarval Batween
	Physician /Medical Examiner	ner	Immediate Ceuse (Final disease or condition resulting in death)	e. //	Due to	tte (or es e consec		n S	small	all	2 Cana	wane	12 month
68760,	tificate be axecuted g physician end as the bunal-trensit	edical Examiner	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disaasa or Injury that Initieted events resulting in death) Last	c		or es e consac or as e conseq							
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ion o	Attending Physician: The lar death.  •ctor: After this certificate he by the funeral director, page		E II / tooldorit	ding (Mo stigation	a of Injury nth, Day Year)	28b. Time of Injury	f 28	c. Injury e Work? 1 \( \supers			now injury occu		
Division	교육하드	Certification:	3 ☐ Suicida 6 ☐ Coul 4 ☐ Homicida dete	mined Zoa. Flat	e of Injury - At I	nome, farm, str	eet, factory,	office	:	28f. Location (S City or Tox	Street end Numi vn, Stata)	ber or Rurel I	Route Number,
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			Dar	sh k	tel	MB		020	0396		Valy	-11, 1	997
	20		30. Name and eddress of parso	on who completed cau	usa of death (Ite	m 23a) (Type,	Print)			01 2.	Delved	len 2	1239
	Sta Registr		31. Deta filed (Ment/4 D1997	) Julia	- Davidson	Mandell	)		7		3-1		



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			2543 M	CHENR	Y S	TREET	1			BALTO,	ΥTTY		N/A	9		
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Baltimore,	- 4 E E		20a. Method of Disposition  20b. Place of Disposition (Nama of cematary) cramatory or other place)  Data 20c. Location - City of Commandation (Nama of cematary) cramatory or other place)											City or Town, S	Stata	
Ë	Page nt: #			Gremation 5 Other (S		lemoval from	Suntil [	1		· · ·	/10/199	7 DU	LANFY	VALLEY	/ MD	
alti	permit. Page: Department of Important: If I any injury or otice.		21. Signatuse of P	Uneral Service	Lioghe	5 /		166						***************************************	110	
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760,	be exician buria	calE	Sequentially list of if any, laading to it causa. Enter Und Causa (Disaasa o	arlying r injury	,								4 1997 7:13P  4c. Country of Death  N/A  ar)  5. Birthplaca (Stata or Fore Country)  10d. Insida City L  1)(1) Yas 2D  Citizan of What Country?  U.S.A.  14. Race - Amarican Indian, Black, Whita, atc.  Specify: AFR. AMERICA  Kind of Businass/Industry  PAINTING CO.  Jan Surnama)  Tyor Town, Stata, Zip Code)  21223  Location - City or Town, Stata  JLANEY VALLEY MD  P.A.  21217  Approximete Intarval Batwae Onsat and Deal			
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rds	requires that the veen signed by th chould be detache													24b. Wara au	topsy findings	
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	ours af							riend's h	ouse		Baltimor					
	Hospital or     124 hours afte     Funeral Dir letely filled in	edicai	29a. Cartifiar (Check only	1☐ Certifyir	ng Phys Examir	nar: On tha b	asis of axam	knowledga, deal nination and/or in	th occurred et the	a tima, data and plac ny opinion, daath occ	e, and due to th urred at tha time	e causai a, data a	(s) and mar nd place, a	nnar as stated. nd dua to tha d	causa(s)	
	To the Hosy within 24 ho To the Fune completely f	Me M	one) 29b. Signatura and	_		and man	ner stated.			ansa number						
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					6	/	1			O.C.M.E.		JUL	Y 5,	1997		

State Registrar

30. Nama and addrass of parson who complated causa of death (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 A REPORT OF THE PROPERTY OF TH

3. Time of Deeth 2:30 PM

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item24a 7-14-97 FilmG749 W.H. Per Doctor Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** Month Dey 17, April 1997 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Delaney Towson Nursing Home Towson
If Under 1 Year If Under 24 Hrs. Baltimore 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthpiece (State or Foreign Country) **Funeral** 1 🔀 M 2□ F Deys Yrs. Director 84 160-18-0349 June 6, 1912 unknown Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland Baltimore Towson 1 ☐ Yes 21 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? daath with 111 West Road 21204 U.S.A. 12. Wes Decedent Ever in U,S.
Armed Forces?unknown
1 ☐ Yes 2 ☐ No
If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 11 Marital Status 1 Never Merried 2 Merried Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 18b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important if item 27 is merked other than any injury or other traumatic event, the Magnitus. Elementary/Secondery (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be unknown unknown 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown unknown 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 □ Donetion 5 ② Other (Specify) in state 21. Signature of Funeral Service License Ronald S. 22. Name end Address of Fecility
State Anatomy Board, 655 W. Baltimore Street Director lee Baltimore, Maryland 21201 confolications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediate Ceuse (Finei diseese or condition resulting in deeth) Examiner Exercibation Obstantive Airway Diferse Examiner sician and burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest P.O. Box 68760. attanding physician for usa as the burie Dementia Physiclan/Medical Due to (or es e consequence of): signed by tha sid be datached to Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? gtube feeding 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No. certificata Division of Vital 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 1 Naturei 5 Pending investigation 1 Yes 2 No 2 Accident

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director;

3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted. 29a. Cartifier

29b. Signeture end title of certifier

29c. License number 29d. Date signed (Month, Dev. Yeer)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

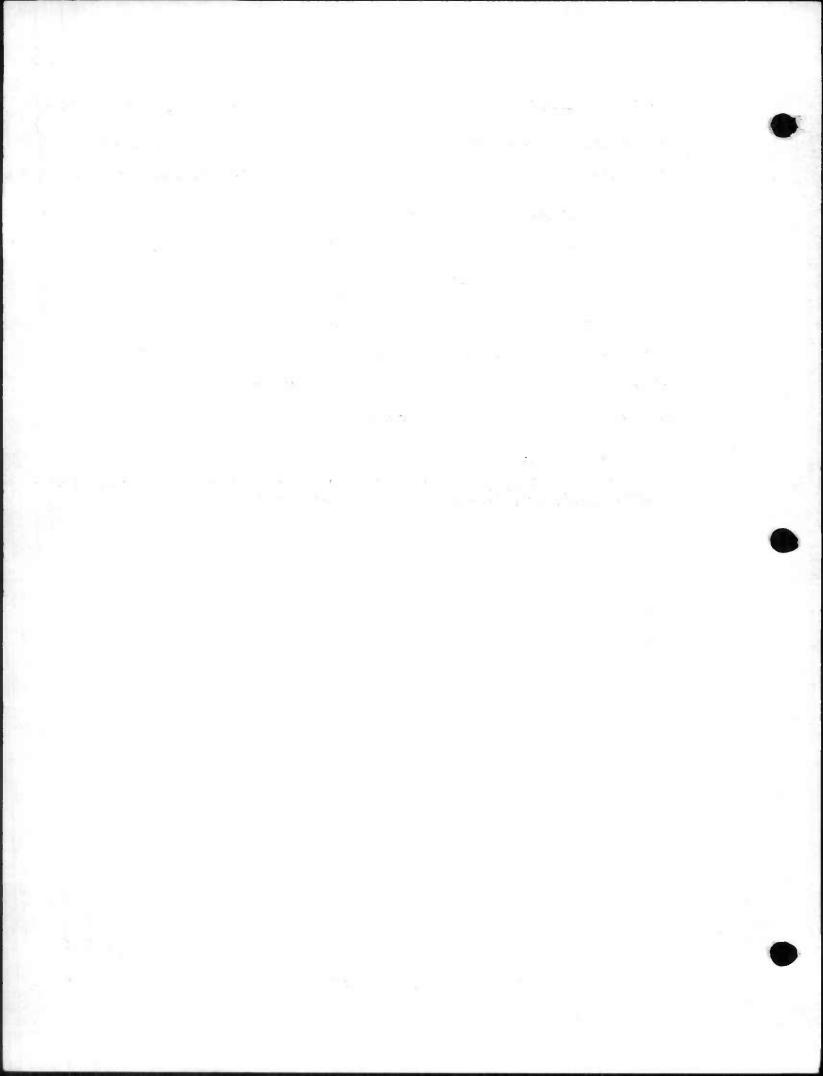
SILVIA SHIH 31. Dete filed (Month, Day, Year)

32. Registrer's Signeture which Davidson-Randalls

ST. PAUL PL., BOB 403 BALTIMORE MD 21202

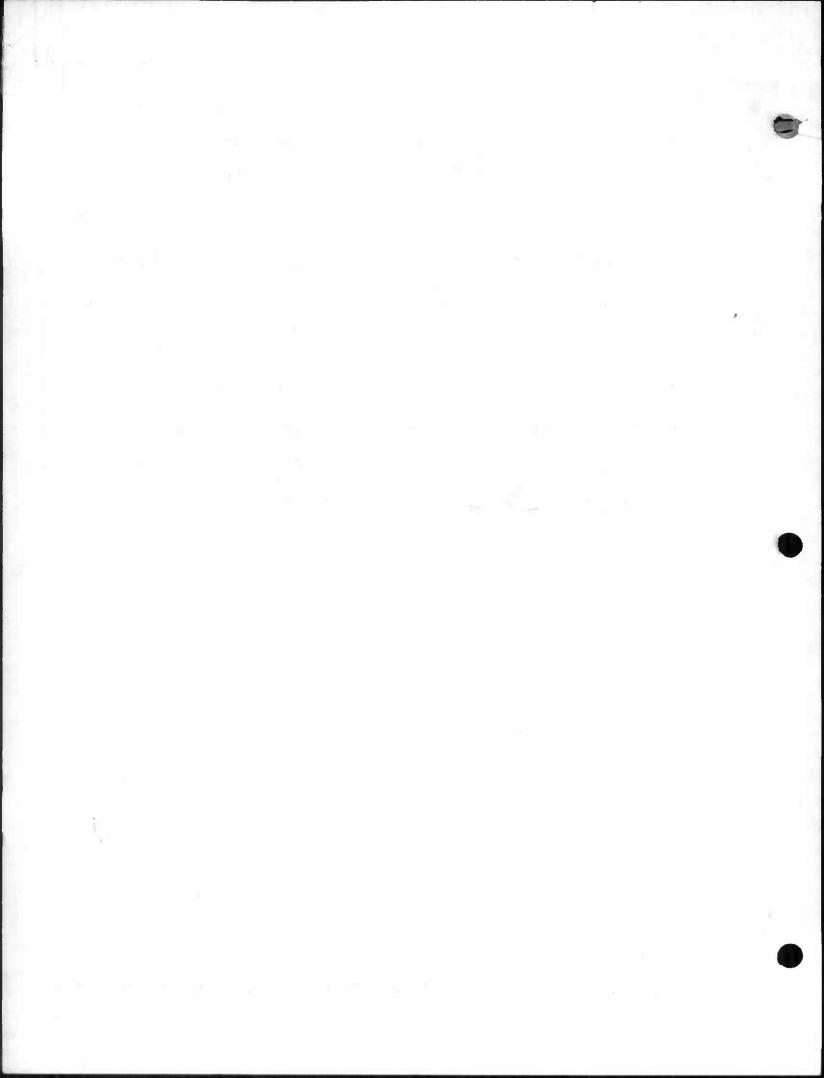
State Registrar

edicai



State of Maryland / Department of Health and Mental Hygiene 97

				C	ertificate o	f Death		Reg. No.		
		1. Decedent's Name (First, Middle, I	Last)				2. Dete of De		V	3. Time of Death
Physi /Med		EDDIE MCFAT	TEN				JULY	02, 19	97	4:47 PM
Exam		4e. Fecility Name (If not institution, g		mber)		4b. City, Town, or I				
	ш	501 E. PRESTO				1	IMORE	N/		
Funera Directo		5. Social Security Number  259-46-0374  Usual Residence of Decedent	.Sex 1—2 M 2□ F	7. Age (In yrs. lest birthd 43 Yrs	Months Day		(Month, Di	th ey, Year) 3 , 1934	Cou	place (State or Foreigr ntry) GA
Brad # #		10e. Stete 10b. County		10c. City, Town or	Location					10d. Inside City Limits
Seath with the Maryland res 23e or 28e-1 show .must be notified at	6	MD N/	Δ		BALT	0.0				ty⊡yYes 2 □ No
the 128a month	Director	MD 1N/			10f. Zip Code			10g. Citizen of	Albet Cou	****
W 10 0	늄				Tot. Zip Code			rog. Citizen of	what Cou	ntryr
death w ms 23s cmust.b	Funeral			PT 313		21202	- " W - Al	U.S.		
O E	1,5	11. Marital Status	Armed F	edent Ever in U,S. 1	If Yes, specify C	f Hispanlc Origin? (S uben, Mexicen, Puert	o Rican, etc.)	Bla	ck, White,	cen Indien, , etc.
8 3	P P	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	TYPES, G	2 No 1953 – ve 1956	1□ Yes 2귳N	o Specify:		Specif	v: B	LACK
8,11	1 P	15. Decedent's			cedent's Usual Occ	unotion		10h Kind of B	in a/l-	distant.
to 2/194		(Specify only highest g	rade completed)	(G	ive kind of work done	ne during most of wor	rking	16b. Kind of B	usmessvin	dustry
	Complet	Elementery/Secondery (0-12)	College (	1-4or 5+)		,		N/A	1	
D BENE		12th 17. Fether's Neme (First, Middle, La:	N/A	UNI	EMPLOYEI	18. Mother's Nan	ne (First, Middle			
and be seen and seen	Be	UNKNOWN	,				KNOWN	, mader comon	10)	
hould be did Menta	2	19a. Informant's Name/Reletionship	(Time Driet)	104 14	allian Address (Cha			0/4 T	Ot 1 7	- 0-3-1
A8 22 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2						et end Number or Ru			State, Zı	) Code)
C 75 M to		PATRICIA MCFA	rten	810	WEBB C7	BALTO,	MD 21;	202	O1 T	0
0 82=8		1 Suriel 2 Cremation 3	☐Removal from	State Cemerery, C	remetory or other p	//ece/	JULY 1			
Baltim Semit. Pag Separtment mportant: I		4 Donation 5 Other (Spec	cify)	GARRIS	ON FORES	T VA CEN	1 1997	OWINGS	MI	LLS, MD
Balti.	à	21. Signature of Funeral Service Lic	ensee	7	22. Name end Add	fress of FacilityBET	rts fui	VERAL H	OME	
0 88 5 5	4	9411.00 A	113	1/4		. CAROLI				21213
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications thet	aused the death. Do not						Approximete Intervel Between
/Medica Examine		Immediate Ceuse (Final disease or condition resulting in death)  e. Hypertensive Atherosclerotic Cardiovascular Disease or conditions Due to (or es e consequence of):  Sequentially list conditions, if eny, leeding to immediate cause. Enter Indexiving.								
exac in en ial-tr	EX	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or es e con	sequence or).				1	
Box 68760, eath certificate be executed ettending physician end for use as the burial-trensit	edicai	Cause (Diseese or injury thet initieted events resulting In death) Lest	C	Due to (or as a cons	sequence of):					
ds, P.O. Box ( ires that the death certifi signed by the ettending d be deteched for use as	3	•	d							
deat deat	Physician	Pert II. Other significant conditions	contributing to d	eath but not resulting in the	e underlying ceuse	given In Pert I.	23b. Dld	tobacco use co	ntribute t	o the cause of death
P.O et the d by the	Į,		Č		, ,		10	Yes 2□ No	3 □ Pro	bably 4 Unknow
s the	by F									
of Vital Records, P.O. Box 68760, Physician: The law requires that the death certificate be executed this certificate has been signed by the ettending physician end ral director, page 2 should be deteched for use as the burial-trensit	Completed							en eutopsy ormed?	6/	fere eutopsy findings reileble prior to empletion of cause
Hes hes	E G							/	of	deeth?
al R							1 🗆	Yes 2 No	11	☐ Yes 2☐ No
of Vital Re Physician: The lav this certificate hes ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:	- · · · - · · · · · · · · · · · · · · ·		26. Piece of Dea	ath (Check only	one)		
of physics this direction	10	1 X Yes 2 No	1 1 1	Inpatient 2 ER/Outpa	tient 3L DOA			idence 6 □Oth	· ·	fy)
Vision of Attending Por death.	atlon:	27. Manner of Death 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident investigati		of Injury 28b. Time th, Dey Year) Injur	у У	jury et /ork? □ Yes 2 □ No	28d. Describe	how injury occur	red	
	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d Zee. Flece	of Injury - At home, farm, ing, etc. (Specify)	street, factory, offic	ee .		Street and Numb wn, Stete)	er or Run	el Route Number,
To the Hospital Within 24 hours To the Funeral	edicai (		eminer: On the b	best of my knowledge, de asis of examinetion end/or ner stated.						
To the	×	29b. Signature and title of certifier	0.		29c. Lice	nse number		29d. Date signe	d (Month,	Day, Year)
		Mana (L.	(1/2 t	6.4		O.C.M.E		JULY 0	3, 1	.997
2		30. Name end eddress of person who	o completed care	se of death (Item 23a) /Tim	oe Print\					
		DITCL	WA MA			eet, Bal	timoso	Mann	land	1 21201
c	tate	31. Dete filed (Month, Day, Yeer)	32. F	tegistrer's Signature		cet, bal	. CIMOT 6	, mary	TallC	L STSAT
Regis		Min 1 / 1997	11	L Savidson-Rand	22					
	10.5	4 1001	0							



ANGELICA M. MEJI	LΑ	
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UNK.97-151 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** Month 1997 10, july 12:20 PM ANGELICA M. MEJIA /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner ROUTE#95 SOUTH RIVERSIDE HARFORD 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🖾 F Yrs. 32 Director 03/26/65 Mexico 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits 1⊠Yes 2□No Director Mexico City NY Queens 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8 Examiner must be Items 23a 47-11 160th Street Funeral USA 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Mexican þ 3 ☐ Widowed 4 ☐ Divorced - Mexican Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th Grade Accountant 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme, oud be and Mental h Be 2 Florencia Mejia Estela Osorio 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Health as Important: If them 27 is any injury or other trau Florencio M. Mejia - Father 1 Bost Street, Yonkers, NY 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Cemeterio Municipal 07/17/97 Mexico 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Unity Funeral Home, Inc., 108 W. North Avenue 21201 - (410) 752-4941 Baltimore, MD and 1. Enter the disease, or complications that caused the beeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, book or heart failure. List only one cause on each line Approximete Intervel Between Onset end Death /Medical Immediate Ceuse (Finel diseese or condition resulting in death) Due to (or es e consequence of): physician and s the buriel-transit certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of): 98 for use es signed by the e Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 000 3 Probably 4 Unknown

**Physician** Examiner

altimore, Maryland

Box 68760

P.O. I

Records,

Division of Vital

page 2 To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifics completely filled in by the funeral director,

peed

hes certificate 27. Menner of Deeth

Physician/Medical g Completed Be 0 Certification:

24a. Wes en eutopsy performed?

26. Piece of Death (Check only one)

24b. Were eutopsy findings eveileble prior to completion of cause of deeth?

25. Wes case referred to medical exeminer? XXYes 2□ No

28e. Date of Injury (Month, Dev Year) 5 Pending investigation

28b. Time of 15

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28c. Injury et Work? 1 ☐ Yes

Other:  $_{4}\square$  Nursing Home  $_{5}\square$  Residence  $_{6}\square$ Other (Specify)  $_{7}\square$  ROADWAY 26. Describe how Injury occurred

281. Location (Greet end Number or Rural Route Number, City or Town, Stete)

29a, Certifier

1 Naturel

2 Accident 3 ☐ Suicide

4 Homicide

28e. Piece of Injury - At horse, ferm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es steted.

\*\*Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated.

29b. Signature and title of certifier

6 Could not be determined

29c. License number O.C.M.E 29d. Date signed (Month, Dev. Year) JULY 11, 1997

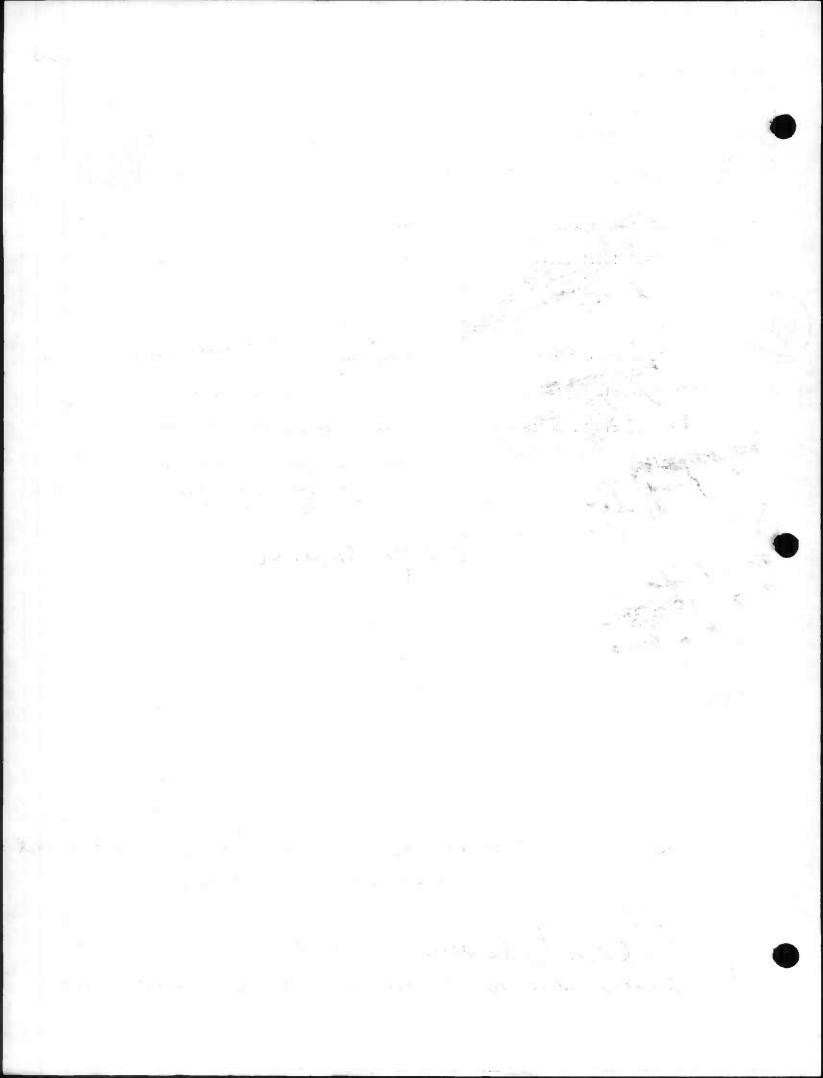
30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

cocke mo Tithou 31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

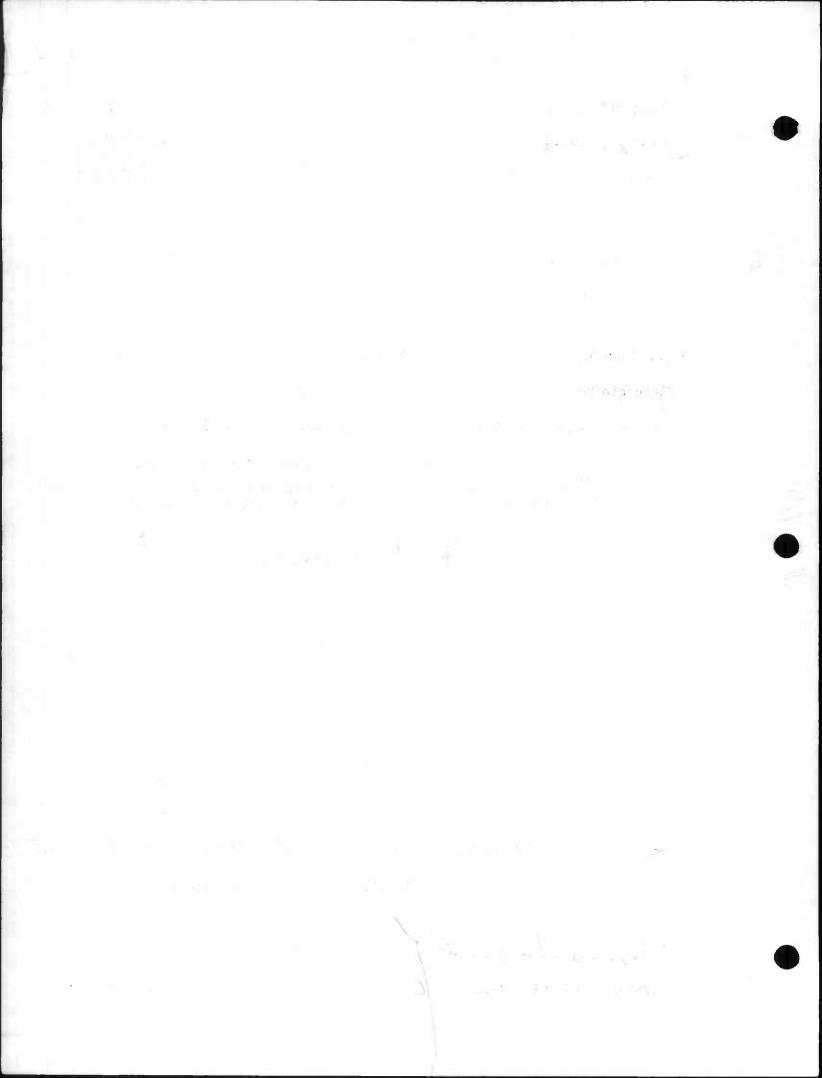
State JUL 1 4 1997 Registrar

32. Registrar's Signature chia Davidson



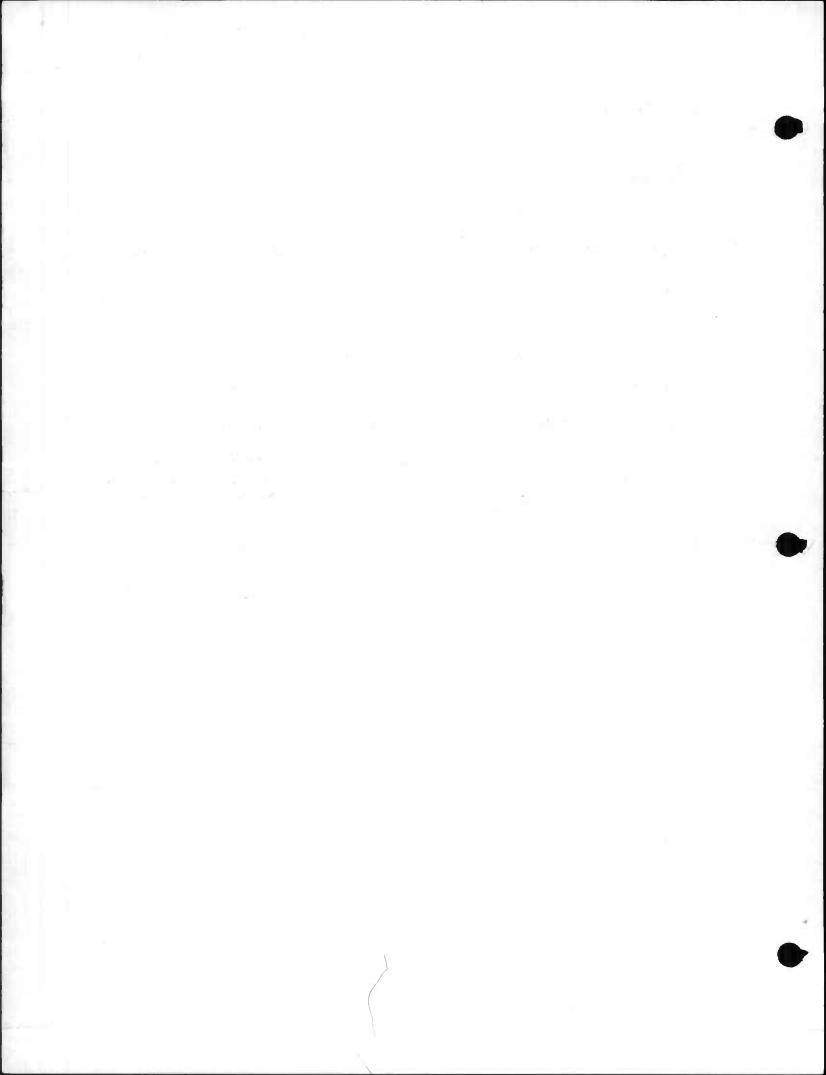
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	INK.97- LORENC		ITEM: 6 16a h 19h ner 1	State of M FH G -749 7-	<b>aryland</b> 31 <b>-</b> 97 e	I / Departme	ent of l ate of	Health and Death		giene 9	1 2	1199
	Physici	U	1. Decedent's Name (First, Middle, La		13				2. Dete of De Month		Year	3. Time of Death
	/Medi	cal	FLORENCIO A. ME.					# O'r T	JULY	10, 1	997	1220PM
1	Examir	ner	4a. Facility Name (If not institution, given ROUTE# 95 SOU					4b. City, Town, or RIVERS			FORD	
	Funeral Director				ge (In yrs. Ie:	st birthdey) If Un Yrs. Monti	dar 1 Yaar hs Deys	If Undar 24 Hrs	8. Date of Birt	h y, Yeer)		leca (Stete or Foreign try)
	aryland show d.at	<u>.</u>	Usual Residence of Decedent  10a. Stete 10b. County		1	Town or Location					10	Od. Inside City Limits
1	IN	Director	NY Queens  10e. Street end Number		Flus	shing	Zip Code			40- Chi411	(h = 1 C = 1 = 1	1⊠ Yes 2 No
16	AILAS)		47-11 160th Stre			101.	Zip Code			10g. Citizen of V	vnet Coun	try r
6		Funeral	11. Maritel Stetus  1 □ Naver Married 21X Marriad	12. Was Dacedant Armed Forces?		. 13. Wes Da If Yes, s	cedant of pecify Cut	Hispanic Orlgin? (S pan, Mexicen, Puerl	Specify Yes or No to Ricen, etc.)	USA 14. Rac Blac	e - Amarica k, White, e	
020	Er. o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giva Yaar or Dates:		1 ☑ Yes	2 □ No	Specify: Mex	ican	Specify	Hispa	anic
21215-0020	vithin 72 ho ns. han "natur se Medical.	Completed	15. Decedent's E (Specify only highest green statementery/Secondary (0-12)	ede completed) College (1-4or s	5+)	STORE (	work dona Tuse retire )WER	during most of wor	rking	16b. Kind of Bu	SMAN	dustry
	Hygie Ober Hygie Hygie Hygie Hygie		12TH Grade  17. Fathar's Name (First, Middla, Last		2	Housew	11e	18. Mother's Nar	me (First, Middle,	-Domes  Maiden Sumern		
Maryland	Annial Annial Ased o	To Be	Florencio Mejia					Estela	Osorio			
lan	2 should he man a summer		19e. Informent's Neme/Relationship (	Type, Print)		19b. Meiling Addr	ess (Stree	t end Number or Ru			Stete, Zip	Code)
	and palith n 27 ser tr		Florencio M. Me	ia - Fath			Str	et, York				
Jor	Pages 1 tent of Hant If the rry or oth		20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3 ☐		20b. Ple- cen	ce of Disposition (in metery, cremetory of	vame of or other pla	ece)	Dete	20c. Location -	City or To	wn, State
Baltimore,	ortmer reant reluny		4 Donetion 5 Other (Specifical Signature of Funeral Service Lice)		M.	aple Grav		metery C	7/17/97	Queens,	NY	
Ba	Deper June on a su		11 Signeture System 1 5 -	then of	0 10	Uni	ty Fu	ineral Ho				th Avenue
	_		23a. Part. Enter the disease, or com shook, or heart feilure. List only	plications that caused	t/he death.	Do not entar than	timon noda of dy	ce, MD 2 lng, such as cardiac	1201 — ( c or respiratory as	410) 75 rast,	2-494	Approximata
	Physician /Medical Examiner	er.	Immediate Ceuse (Final disease or condition resulting in deeth)	a	He	es e consequence	Thi	uner				Intervel Between Onset end Death
	and transit	xaminer	Sequentially list conditions, if eny, leading to immediate	b	Due to (or e	es e consequence	of):					
68760,	eath certificate be exex attending physician ar for use as the burial-t	ai Ex	ceuse. Enter Underlying Ceuse (Diseese or Injury	c								
687	ficate physis the	edic	thet initieted events rasulting In death) Lest		Due to (or a	is a consequence of	of):				i	
Box	n certi	N/U		d								
	0 0 0	Physiclan/Medical	Pert II. Other algnificent conditions of	ontributing to death b	ut not resulti	ing in the underlyin	g ceuse gi	iven in Part I.	23b. Did 1	obacco usa co	ntribute to	the cause of death?
P.0	that the de ed by the detached	Phy							10	Yes 20 No	3 Prob	pably 4 Unknown
	Se un es	þ				<u> </u>				,	041 141	A C- d-
Records,	2 S	Completed								an eutopsy med?	eve	ere autopsy findings bilable prior to npletion of ceuse deeth?
al H	The age								10	res 2 No	1□	Yes 2□ No
Vital	ysiclan: The is certificate director, pag	Be c	25. Was cese referred to medicel examiner?	Hospitel:			Ot	hor:	eth (Check only o			ROADWAY
o		- L	1 ☑ Yes 2 ☐ No 27. Manner of Death	28e. Dete of Inju	ry 2	R/Outpatient 3 Bb. Time of	28c. Inju	4 LI Nursing F	fome 5 ☐ Resident Re	ience KIXOth		NOADWAI
ion	Attending or death. ector: After by the fune	atlo	1 ☐ Neturel 5 ☐ Pending investigation	7-10-9	7 Yeer)	Injury M		ork? ]Yes 2/12/No	bescen	se/in	into	accident
Division	al or Attending Ph s after death. I Director: After th ed in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Plece of Inj	ury - At hom	e, farm, street, fec	tory, office		28f. Location (S City or Tox	street end Numb	er or Rura	I Route Number,
	oftal or urs afte ral Dir illed in				HI	BAUAT			I-95	S		
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifying Ph	ysician: To the best of	examinetion	edge, death occurr n and/or Investigat	ed et the ti ion, in my	ime, date end plece opinion, death occu	e, end due to the urred et the time,	ceuse(s) end me date end plece,	nner es st end due to	eted. the cause(s)
	To the vithin 2 To the comple	Mec	29b. Signature and title of certifler	and mannar sta	2.0U.	T:	29c. Licen	se number		29d. Date signe	d (Month, I	Day, Year)
	F 5 F 0		6 Qrum	Lookal	W		0.	C.M.E		JULY	11,	1997
	4		30. Name end eddress of person who	completed cause of d	leeth (Item 2	3e) (Type, Print)						
				FE, MD			tree	et, Balt	imore,	Maryl	and	21201
	Sta Registr		31. Dete filed ( <i>Month, Day, Year</i> ) <b>JUL 1 4 19</b>	32. Ragistr	ar's Signatur	son-Rande M	2-					

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 21200 Item1 7-14-97 FilmG749 W.H.Per DOCTOR Certificate of Death 1. Dacedent's Nema (First, Middle, Last) 2. Data of Death Month Yaar 2:30pm **Physician** MILLER HORON 07 97 /Medical 4e. Fecility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LAUREZ REGIDNAL Laurez If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** 1 M 2 □ F Yrs. JUNE Director 216-86-7200 16, 1970 Usual Rasidance of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits MD N/A BALTO XXYas 2 No 288-11 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1104 E. HOFFMAN ST 21202 U.S.A. 12. Wes Decedant Evar in U,S. Armed Forces? 14. Race - Amaricen Indian, Black, Whita, atc. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 1 Yas 2 No If Yes, Give X Yaar or Dates: 1 Nevar Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: BLACK ğ 3 Widowed 4 Divorced Completed 15. Decedant's Education (Spacify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry d 2 should be filed within 7, and Mental Hygiene.
7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) 10th N/A N/A UNEMPLOYED 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be 2 WILLIE JAMES DARLENE MILLER 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) permit. Pages 1 and 2 st Depertment of Health and Important: If Item 27 is n any injury or other traun DARLENE MILLER/MOTHER 1104 E. Hoffman ST BALTO, MD 21202 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20e. Mathod of Disposition Data 20c. Location - City or Town, State ↑ Buriel 2 □ Cramation 3 □ Removal from State 4 □ Donation 5 □ Other (Spacify) JULY 10 ZION CEM 1997 BALTO, MD 21. Signature of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility BETTSFUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213 avecia 23a. Part1. Entar the diseasa, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician SARCOMA OF /Medical Immediate Ceuse (Final disaasa or condition resulting in death) Examiner Examiner sicien end buriei-transit Sequentially list conditions, if any, laading to immadiata ceuse. Entar Undarfying Cause (Disease or Injury that initiated evants rasulting in daath) Last Box 68760, ettending physicien for use es the burie Physician/Medical Due to (or as a consequence of): P.0. Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to tha csusa of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Wara autopsy findings availebla prior to completion of ceusa of daath? 24a. Was an autopsy Completed parformed? certificete hes 1 ☐ Yas 2 ☐ No 25. Was cesa rafarrad to medical axaminar? 26. Placa of Daath (Chack only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Yas 2 No 10 1 fnpatiant 2 □ ER/Outpatiant 3 □ DOA within 24 hours efter deeth.
To the Funeral Director: After this completely filled in but the funeral 27. Mannar of Death 28d. Dascriba how injury occurred Certification: 1 Natural 2 Accidant 5 Panding investigation 1 ☐ Yes 2 ☐ No 6 Could not be datarmined 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homlcida Medical 29a. Cartifiar 😰 Certifying Physician: To tha bast of my knowledge, death occurred at the time, data and place, and dua to the causa(s) and mannar as statad. (Check only one) 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifiar 29d. Date signed (Month, Day, Yaar) 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Frint) Dusen ad Laurel, MD 20707 Chew 7300 Van abel 31. Date filad (Month, Dey, Yeer 2. Ragistrar's Signatura who Devidson-Ro

State Registrar



State of Maryland / Department of Health and Mental Hygiene 97 2 1 2 0 1

			Cei	tificate of Death	Reg. N	10.
Dharai	ion	1. Decedent's Name (First, Middle, Last)		4442	2. Date of Death	3. Time of Deeth
Physic /Med		JULIA		MASKELL		1997 12:10p
Exami		4a. Facility Name (If not institution, give street end n				c. County of Deeth
		GOOD SAMARITAN	HOSPITAL	BALT	MORE	N/A
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 H Months Deys Hours M	rs. 8. Date of Birth	9. Birthplace (State or Forei
Director		214-01-5818 ¹□M 2☒F	80 Yrs.	Montala Daya Hodis Wi		1917 Maryland
9 *		Usual Residence of Decedent  10a. State 10b. County	10- 00- T		,	
the Maryland 28a-f show tolffied at	-		10c. City, Town or Lo	cation		10d. Inside City Limi
the M 28a-f notifie	cto	Maryland N/A	Baltimore	)		1 ▼ Yes 2 □ N
vith the Maryla or 25a-f shor be notified at	Director	10e. Street end Number		10f. Zip Code	10g. C	Citizen of Whet Country?
23a Mark	0	6641 Walther Avenue	Apt. F	21206	Ur	nited States
y de	Funeral	Armed F	cedent Ever in U,S. 13. \ Forces?	Vas Decedent of Hispanic Origin? f Yes, specify Cuben, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
8	by F	If Yes, C	2 🔀 No live	I□Yes 2X No Specify:		
8 41 10		3 ☐ Widowed 4 ☐ Divorced Year or				MILLE
可料體	Completed	15. Decedent's Education (Specify only highest grede completed	16a. Deced (Give	lent's Usuel Occupation kind of work done during most of w DO NOT use retired)	vorking 16b.	Kind of Business/Industry
X Gaz V	d L		(1-4or 5+)			
N 2528		10 17. Father's Name (First, Middle, Last)	Homema			Own Home
and de la la la la la la la la la la la la la	Be	George Noll			ame (First, Middle, Maide	· ·
T West	2			Kathe		ffer
Maryland d 2 should be fill th and Mental Hy 7 is merked oth treumetic even		19a. Informant's Name/Relationship (Type, Print)		g Address (Street end Number or		
C = N -		Mr. Gerald F. Maskell/Husband 20e. Method of Disposition				nore, Maryland 21206
O SECTION OF		1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from	State Cemetery, cren	sition (Neme of natory or other plece)	Date 20c.	Location - City or Town, State
Ling Pa		4 ☐ Donetion 5 ☐ Other (Specify)	Moreland M	emorial Park	7/14/97 Ba]	ltimore, Maryland
Baltimore, permit. Pages 1 ar Department of Hear Important: If Item 3 any injury or other once.		21. Signature of Funeral Service Licensee Bria	n A. Willem 22	. Name end Address of Fecility	eonard J. Ruck	Funeral Home, Inc.
M VUE 4 O		Duan a. Will	$\sim$ 53	05 Harford Road B	altimore, Maryl	land 21214
Physician /Medical Examiner	ı,	23a. Pert1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	cute Pu	Imenary	Emloles	Approximete Intervel Between Onset end Death
p ±	ine	<b>a</b> b				1
Ords, P.O. Box 68/60, requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Examiner	Sequentially list conditions, if eny, leading to immediate	Due to (or es e conseq	uence of):		
68 / 60, ificate be ex g physician test the burial	<u>e</u>	Cause (Diseese or injury				
phys the	Medical	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):		
certifica ding ph		d				
BOX Bath cer attendir for use	cian					
is, F.C. BOX es thet the death ce igned by the attendi	Physician/	Part II. Other significent conditions contributing to	death but not resulting In the ur	derlying gause given in Part I.	\	co use contribute to the cause of deat
thet the ed by the detache	된	Chronice Len	shertu	- Loutenic	a 1□ Yes	2 No 3 Probably 4 Unkno
aires sign d be	d by	-1 0 B	0 1	1 1/ 1	24a. Was an aut	opsy 24b. Were eutopsy findings
v require	Completed	orch Splen	ie onter	I+ Hometer	performed?	
HeC e law has b	Id II					of deeth?
The is					1 ☐ Yes	2 1 ☐ Yes 21 ☐ No
VITAL I	B	25. Was case referred to medical examiner?	2		eath (Check only one)	
or hysic this c	2		Inpatient 2 ER/Outpetien		Home 5 Residence	
ing F	00		of Injury 28b. Time of Injury Injury	28c. Injury et Work?	28d. Describe how inj	ury occurred
UNUSION OF VICAL RECORDS,  To the Hospital or Attending Physicien: The law requires the within 24 hours effect death.  To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be	Certification:	2 Accident investigation		M 1 Yes 2 No	1	
or At or At or At or At or At or At	in the	determined 200. FIBO	e of Injury - At home, farm, stre <del>ling, et</del> c. <i>(Sp</i> ec <i>ity)</i>	eet, factory, office	28f. Location (Street e City or Town, Sta	end Number or Rurel Route Number, ite)
urs e	ပို	20-0-1				
Hose 24 ho Fune tely fi	edlcai	2 Medical Exeminer: On the	oesis of examination end/or inv	occurred et the time, date end ple estigation, in my opinion, death oc	ce, end due to the ceuse( curred et the time, date er	s) end menner es stated. nd place, end due to the ceuse(s)
the the	Med	end mai	nner stated.			
5 × 5 0	100	29b. Signature and title of certifier	//	29c. License number	29d. D	ate signed (Month, Dey, Year)
1		- War /h +	tela m	020396		July 10, 199
4		30. Name end eddress of person who completed cal		Print)	/ 2	
\		DAVIS HAHN, M		LOCH RAVEN	1 BZVO.,	MO 2/2 39-29%
Sta	ite	31. Date filed (Month, Dey, Year) 32.	egistrar's Signature	200	,	

WRC 97-3749-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. CARLTON State of Maryland / Department of Health and Mental Hygiene McNEIL Items: 23a part I,27,28a-f per MEO G-750 8/6/97 dh Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Death **Physician** Yee CARLTON L. 08, MCNEIL JULY 1997 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner JOHNS HOPKINS HOSPITAL BAYVIEW BALTIMORE ff Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 6. Sex 10 M 2□ F 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months Yrs. 213-70-4358 35 Director July 26, 1961 MARYLAND Usuel Residence of Decedent r 28a-f show 10a, State 10b. County 10c. City, Town or Locetion 10d. Inside City Limits Director MD. N/ABALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ö must be 23a 3201 E. LOMBARD STREET 21224 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Yes 2 XNo Specify: þ Specify: 3 ☐ Widowed 4 [X Divorced WHITE Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 2 12 CARPENTER LOCAL 516 Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 12 should be fi h and Mental F I's marked ot Be JAMES LOUIS McNEIL SHIRLEY MAE WOOSLEY 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Heelth ar
Important: If Item 27 is
any injury or other trau REGINA CHAVIS/FIANCE 3201 E. LOMBARD STREET, BALTIMORE, MD. 21224 20b. Plece of Disposition (Name of cametery, cremetory or other placa) 20e. Method of Disposition 20c. Location - City or Town, State Dete XX Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) PARKWOOD CEMETERY 7/11/1997 BALTIMORE, MD. 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility LILLY & ZEILER INC. 1901 EASTERN AVENUE/21231 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Finel ALCOHOL AND COMBINED DRUG INTOXICATION diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): physician a Box 68760. Due to (or es e consequence of)

Physician/Medical by Completed page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, to Be 2 Certification: in 24 hour.
the Funeral Direction Medical

signed l

peen

certificate

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Records,

Division of Vital

Pert ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was en eutopsy performed? 25. Wes cese referred to medical 28. Piece of Deeth (Check only one) XVes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Deeth 28a. Dete of Injury (Month, Day Yeer) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Naturel 1 ☐ Yes 2 (X)(No found 4:20M 2 Accident found 7/8/97 unknown 3 Suicide Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3201 E. Lombard Street, 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide at residence Baltimore, Maryland 29a. Certifier

6 State Registrar 29b. Signature and title of certifie

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

\*\*Medical Exeminer: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29c. License number 29d. Date signed (Month, Dey, Yeer) O.C.M.E. JULY 08, 1997 end eddress of person who completed ceuse of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

4:46 AM.

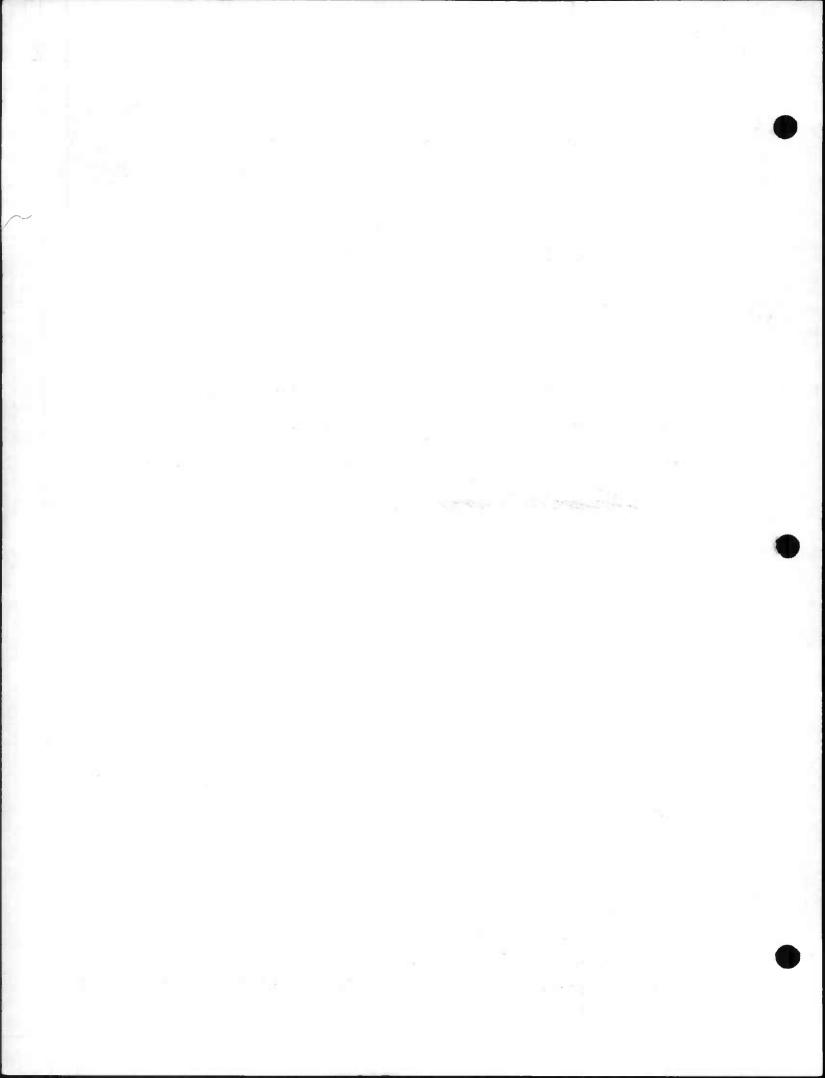
1/OKYes 2 □ No

Unknown

24b. Were eutopsy findings evelleble prior to completion of ceuse of deeth?

2 No

Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 97 2

					Certificate of	of Death		Reg. No.	21203
Physiciai		1. Decedent's Nema (First, Middle, L	ast)		•	-	2. Data of Da Month	ath	3. Tima of Death
/Medica		WILL	IAM	17	ILLER		JULY		197 10:281
Examine	er	4a. Facility Name (If not institution, gi				4b. City, Town, or			f Death
		Liberty Medica		1	thday) If Under 1 Y	Baltin		City	
Funeral Director		309-16-0723	Y	76		aar If Undar 24 Hrs lys Hours Min.	8. Date of Birt June 1,	7921	9. Birthplece (Steta or Foraig Country) Minnesota
pu a		Usual Rasidence of Dacedant  10e. Stete 10b. County	10	c. City, Towr	or Location				10d. Inside City Limits
f short and at	5	Maryland City	10	o. o.,, , o.,,	Baltimor				1 ☐ Yas 2 ☐ No
the 28a-	Directo	10e. Street end Numbar			10f. Zip Coo			10g. Citizan of Wh	
		4004 Fords Lan	e Apt. 1B		212				. A.
death ms 2 Lmus	Funeral	11. Marital Status	12. Wes Decedent Ever	r In U,S.		of Hispanic Origin? (S Cuben, Maxicen, Puar	Specify Yes or No	14. Race	- American Indian,
Exam	D,	1 ☐ Never Marriad 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Detes:		1 Yas 2		to Rican, atc.)		White White
	ped	15. Decedant's E (Specify only highast gi	ducetion	16a.	Decedant's Usual Oc	cupation ona during most of wo	dina	16b. Kind of Bus	Inass/Industry
INH	uple	Elementary/Secondary (0-12)	College (1-4or 5+)		lifa. DO NOT usa ra	tired)	KING		
	Сошрі	12	2		Custo				ore Hebrew
DE PROPERTO	Be	17. Fethar's Nama (First, Middle, Las	t)			18. Mother's Ne	me (First, Middla,	Maidan Sumame,	)
d Mer d Mer marks marks	0	Homer H. Miller	T B	1.00	A			. Peatso	
d 2 should by the and Menth of the marked traumation		19a. Informant's Name/Ralationship  Jewel Miller - w	. , ,			eat and Number or R ane Apt. 1			
Hear Z	1	20a. Mathod of Disposition	2	20b. Place of	Disposition (Nama o		Data		ity or Town, Stete
omnit. Pages 1 at Nepartment of Hea mportant: if Hem. iny injury or other IRCs.		1 ☐ Burial 2 🖾 Cramation 3 [ 4 ☐ Donation 5 ☐ Othar (Special	Ramoval from Stata		y, cramatory or other Crematory		4,1997	Baltimor	
Departition of the post of the		21. Signature of Funaral Service Lice	Colon H		22. Nama and Ad Eckhardt 11605 Re	Funeral C	hapel Rd. Owi	nes Mill	s, Md. 21117
		23a. Parti. Entar the disaase, or con shock, or haart failura. List only	nplications that cousad tha	daeth. Do n				1407	Approximete tntarval Batween
Physician		,							Onset end Deeth
/Medical Examiner		Immediata Causa (Final disaasa or condition	9	SEP	315				1 DAY
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	Physician/Medical	rasulting in death) Last			onsaquance of):  ARTER	y Dis	EASE		Unknow
deeth cer attendir	2	Part II. Other planificant conditions	contribution to death but no	a a a sublina a la	All a considerabilities and a considerabilities	niver in Cont.	OOL DIA		
the cache	пуs	Part II. Other significant conditions			the undariying couss	givan in Part t.			ribute to the cause of death  □ Probably 4 Ø Unknov
	y y	- DIABETE	3 MELL	ITUS				TOS ZLINO	Probably 4 Official
requir been s should	neted (	- HYPERT	ENDON				24a. Wes perfo	an eutopsy rmad?	24b. Wara autopsy findings eveilebla prior to completion of causa of deeth?
The law ate has page 2		- SIP CORONA	RY ARTER	v 131	1-PASS	GRAFT	101	as 200 No	1 □ Yas 2 No
certificate		25. Was cesa refarred to madicel	/ 11/2/2/3	/ 12/	, , ,	•	ath (Check only o		
. K w o		axaminar? 1 ∐ Yas 2 🚉 No	Hospital: Inpatiant	2 ER/Out	patiant 3 DOA	Other:		dance 6 Other	(Specify)
ath. r: After this		27. Mannar of Death  1  Natural 5 Panding 2 Accidant Invastigation	28a. Data of Injury (Month, Day Yea	28b. T	ima of 28c. I	njury at Work? I □ Yes 2 □ No		now Injury occurred	
tal or Attending P rs after death. al Director: After ted in by the funer.	Ser IIIIC	3 ☐ Suicida 6 ☐ Could not to datarmined	28a. Place of Injury - building, atc. (S	At home, fai	m, straet, factory, off	се	28f. Location (5 City or Tow	Straat and Number vn, State)	or Rural Route Number,
n 24 hour n 24 hour n Euner pletely fil	ealcal	29a. Cartifiar Certifying Pl (Check only one) 2 Madicat Exa	nysician: To the best of my miner: On the bests of exe and manner stated.	y knowledga, mination and	daath occurred at th	e time, data and place by opinion, death occu	e, and dua to tha curred et the time,	cause(s) and mani data end place, an	nar as stated. d dua to the causa(s)
To the To the comp	Ξ	29b. Signeture and titla of certifiar	0 100			ansa number	1		(Month, Day, Year)
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State Registrar		31. Juliag (Mantagg 7 ear)	Julia 3 De Miliars	SHAME	2	,			

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State of Maryland / Depa

artment of Health and Mental	Hygiene	9	7	2	2	0	į
tificate of Death	Reg. No.						

111 Penn Street, Baltimore, Maryland 21201

						Ce	rtificate	of D	eath	F	Reg. No.		
	T-1.		1. Decedent's Name (First, Middle, L	ast)						2. Date of Dea	ath	2-00	3. Time of Death
	Physic		Benny Clevel	and McGri	ff					JULY	Day 10, 1	Yeer L 9 9 7	2211PM
7	/Medi Examii		4a. Facility Name (If not institution, gi					4b	. City, Town, or L			unty of Deeth	221111
1	EAUIIII	101	ST. JOSPEH HO	CDTTAT	r D				TOMCON				OF COUNTRY
-	Comment					last birthday)	If Under 1	Year	TOWSON If Under 24 Hrs.				RE COUNTY
	Funeral Director			1⊠M 2□F	46	Yrs.	Months [	Days	Hours Min.	8. Date of Birth (Month, Day March 6			place (State or Foreign ntry) h Carolina
	land		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				- 4	1.	IOd. Inside City Limits
	f sh	ō	Maryland Poltin			C 1		11.					1 ☐ Yes 2√2 No
	the 288	Director	Maryland Baltim  10e. Street and Number	ore		Coci	ceysvi]				10a Citizan	of Whet Cou	21
	with or	ō		0. 1							rog. Okizon		nuy?
	eath	era	1085 Misty Lynn	12. Was Decede		S 12		030	nanio Origin? (Sr	anoifu Van ar Na	14	USA Race - Americ	can Indian
21215-0020	n 72 hours efter death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force  1  Yes 2  If Yes, Give  Year or Dete	No No		If Yes, specify		panic Origin? (Sp., Mexicen, Puerto Specify:	Ricen, etc.)		Black, White, ecify:	etc.
P	2 hor		15. Decedent's E	Education		16a. Dece	dent's Usual C	Occupat	ion		16b. Kind o	of Business/In	ack
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an	V to D .	Be c	To als T	W-C							State of		
2	should in marked	7	Jack L.  19a. Informant's Name/Reletionship		riff	40h 84a00	a Addana /	Name 4 a	Esterl		- 0'*T-	Barı	
Maryland	이프로								nd Number or Rui				
	t Health tem 27 other tr		Isabelle McGriff	/Wife	00h B				n Circle		-		lle 21030
Baltimore,	00-6		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [	☐Removal from Sta	^	emetery, crei	sition (Name natory or othe	er place	)	Date	20c. Loceti	on - City or To	own, State
E			4 Donation 5 Other (Speci			ılaney	Valley	7 Ga	rdens 7	7/17/97	Timo	nium, l	Maryland
a	permit. Departm Importa any inju		21. Signatura et Fuperal Service Moe	nageo Da	11 .		2. Name end A	Address	of Facility				
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		П		-	sed he death	h. Do not ent						PID Z	Approximate Interval Between
	Physician		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lind.										
	/Medical		Immediate Cause (Final	1	to	90 1	1= (	-0	· brasca	1	0: -		
	Examiner		disease or condition resulting in deeth)	e. /1V	Pro	xtens	ur co	VKX	· onesce	ilar 1	rise	are	
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	eath certificate be executed ettanding physician end for use es the buriel-transit	xar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (o	ras a consec	uence of):						
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87	ate fhysi	edicai	that initiated events resulting In death) Last	0.	Due to (or	r as a conseq	uence of):						
9 x	ing p	Σ.		a.									
<b>B</b> 0)	th ce	an		d									
	D m D	sician	Part II. Other significent conditions	contributing to death	but not resu	ulting in the u	nderlying ceus	se giver	n in Part I.	23b. Dld te	obecco use	contribute to	the cause of death?
P.0	by the	Phy								101	res 2□ N	lo 3□Pro	bably 4 Unknown
	as that igned b	by											
Records,	- w 0									24a. Wes a	an autopsy	24b. W	ere eutopsy findings
8	w requ	Completed								perfor	med?	co	alleble prior to mpletion of ceuse deeth?
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ल										1/KY	es 2□N	0 1	Yes 2□ No
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of	2 000	1   Inpatient 2   MEH/Outpatient 3   DOA   4   Nursing Home							ome 5 Resid	ence 6 🗆	Other (Special	(y)	
	ng P fter t inera	ii o	27. Manner of Death  Naturel 5 ☐ Pending	28a. Date of I (Month,	njury Da <i>y Year)</i>	28b. Time of Injury	28c.	. Injury a Work?	at	28d. Describe h	ow injury or	curred	
Division	Attending r deeth. sctor: After by the fune	ati	Accident Investigation	М	1 🗆 Y	es 2 No							
Ξ	or Attend after deeth Director: A	ŧΨ	3 Suicide 6 Could not to determined	office				umber or Rura	al Route Number,				
Ω	safte safte al Dir ed in	Certification:	the distribution of the following of th										
	ospit hour inera ly fills		29a. Certifier 1□ Certifying Pl	hysician: To the be	st of my know	wledge, death	occurred at t	the time	, date and place,	end due to the c	ause(s) and	manner as s	teted.
	To the Hospital or Attending Ph within 24 hours aftar deeth. To the Funeral Director: After th completaly filled in by the funeral	edical	(Check only one) 2 Medical Example (Check only one)	miner: On the basis and manner		ion and/or in	estigation, in	my opii	nion, death occur	red at the time, o	date end pla	ce, and due to	o the ceuse(s)
	To the within To the Comp	X	29b, Signature and title of certifier	/ /	1	$\sim$	29c. L	icense:	number	2	29d. Date si	gned (Month,	Day, Year)
			Va.	1-0	ode	()	_	C	ME		7777	7 1 1	1007
	1.		30 Named and	Complete	d docth /**-	020\ /T ::		· C ·	M.E.		JULY	11,	199/
	10		30 Marrie and address of person who	completed ceuse of	ı death (item	ı∠Ja) (Type,	rrint)						

State Registrar

31. Date filed (Month, Day, Year)

JUL 1 4 1997

32. Registrarises

State of Maryland / Department of Health and Mental Hygiene

NAGLE Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Month Dey ALAN WILCOX NAGLE, JR. JULY 06,1997 1:30 P /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 8307 LOCH RAVEN BLVD. BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 217-48-7235 Yrs. Director 56 June 5, 1941 MARYLAND Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD. BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? must be нтв 23в 8307 LOCH RAVEN BLUD. Funeral 21286 U.S.A. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2XXNo Specify: 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) PRIEST RELIGIOUS Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 25 Pages 1 and 2 should be ment of Health and Menta tant: If Hem 27 is marked ALAN W. NAGLE, SR. PHYLLIS IRENE HORNER 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) REV. IAN DORNIC/FRIEND 2807 MOUNTAIN ROAD, JOPPA, MARYLAND 21085 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete ŏ WOODLAWN CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) 7/10/1997 BALTIMORE, MD. 21. Signature of Funeral Sovice Licensee 22. Name end Address of Fecility LILLY & ZEILER INC. 1901 EASTERN AVENUE 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** adio vesula-D Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examiner physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or as e consequence of). 98 signed by the e Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown by been sig 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed Division of Vital I Be 25. Was case referred to medical 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home Statement 6 Other (Specify) XYes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this Hospital or Attending Physics 24 hours effer death.
 Funeral Director: After this letely filled in by the funeral director. 27. Menner of Deeth 28a. Date of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 I Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner es steted.

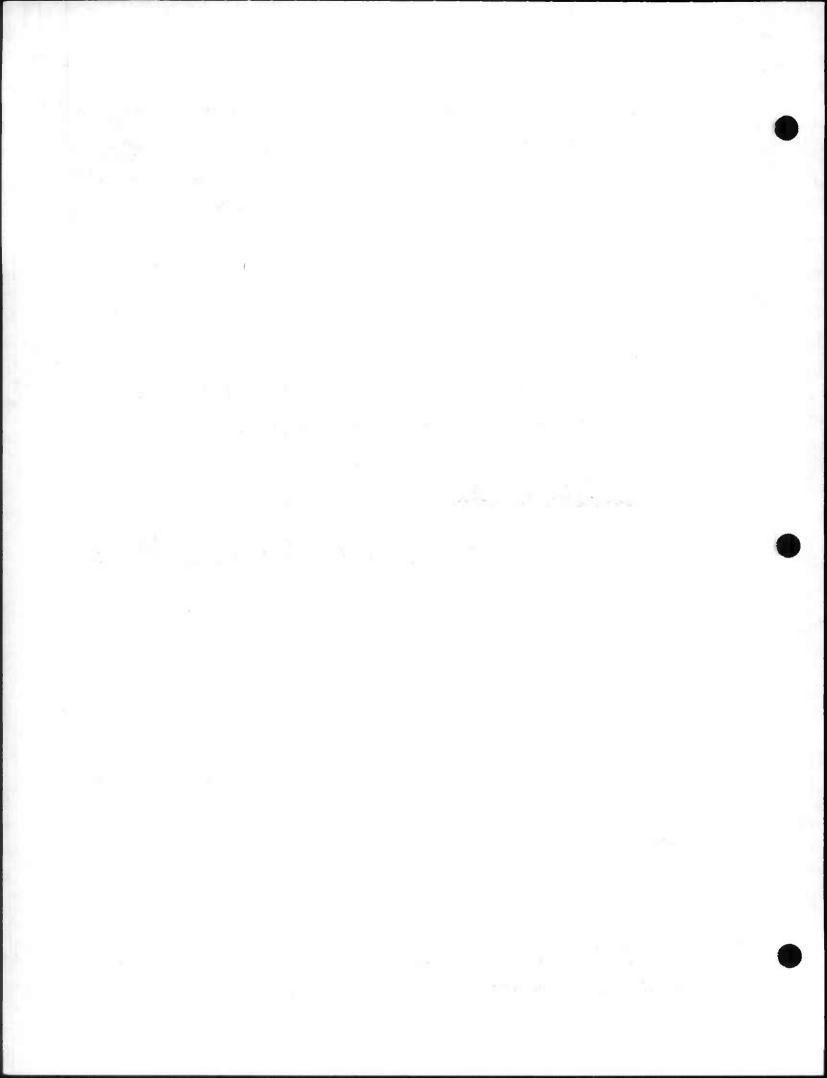
Addical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated. 29s. Certifier Medical To the Hos within 24 h 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) OCME JULY 07, 1997 completed cause of death (Item 23e) (Type, Print) Afon when

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Dey, Year)

JUL 1 4 1997

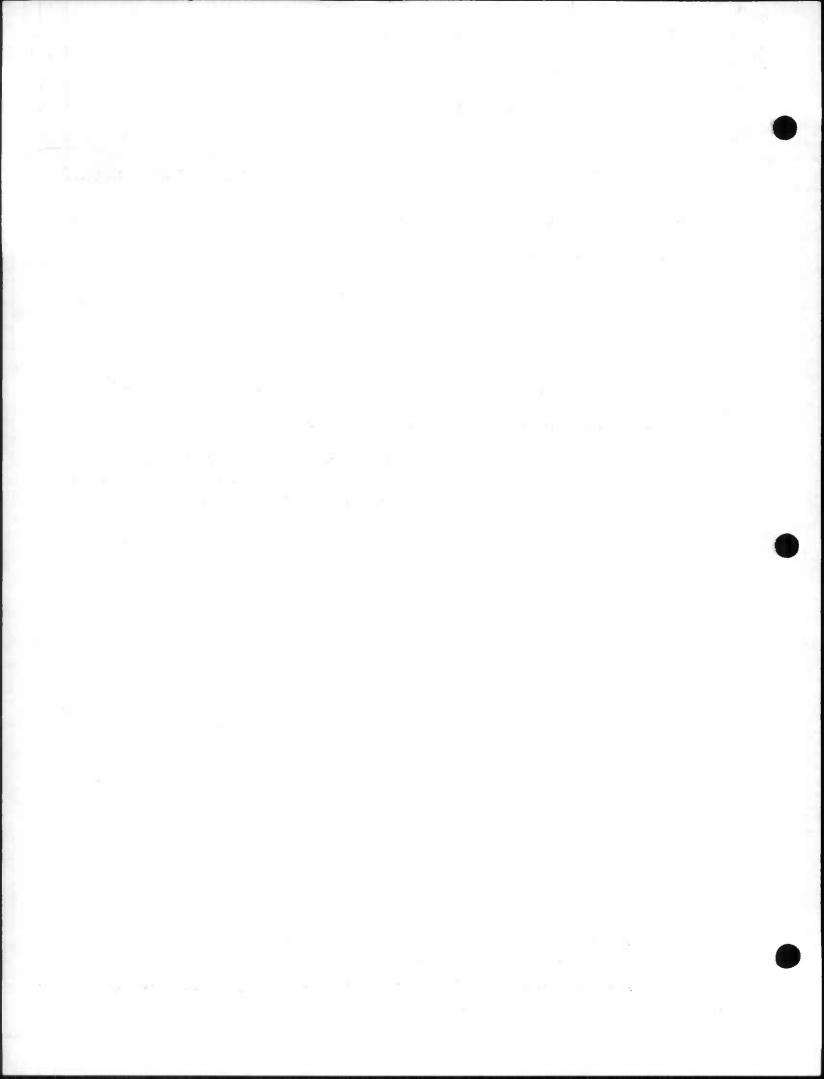
**DHMH 16 Rev 6/95** 



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	Medic amin	_	4e. Fecility Name (If not institution, gir		MICL	ew oak	.00		4b. City, Town,	or Location of De	1	inty of Death		AI.
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	eral ctor			Sex 7. Ag	e (In yrs. i	last birthday) Yrs.	If Under Months 9	r 1 Yeer Days 1	If Under 24 I Hours N	lin. (Month,	Birth Dey, <i>Year</i> ) <b>7,</b> 1996	Cou	plece (Stete or intry) ryland	Foreig
and w	=		10a. Stete 10b. County		10c. City	, Town or Lo	cation						10d. Inside City	Limits
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215-0020	Scal S		15. Decedent's E (Specify only highest gr			16e. Dece	dent's Usu	al Occup	petion during most of d)	working	16b. Kind o	of Business/Ir	ndustry	
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Mar		-	19a. Informent's Neme/Relationship				•			Rural Route Nun				225
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,			Theod	uM. K	06-	0			O.C.M	.E.	JULY	08,	1997	
- /			30. Name and address of person who	completed cause of de	eath Item	23e) (Type	Print)							

111 Penn Street, Baltimore, Maryland 21201

State Registrar



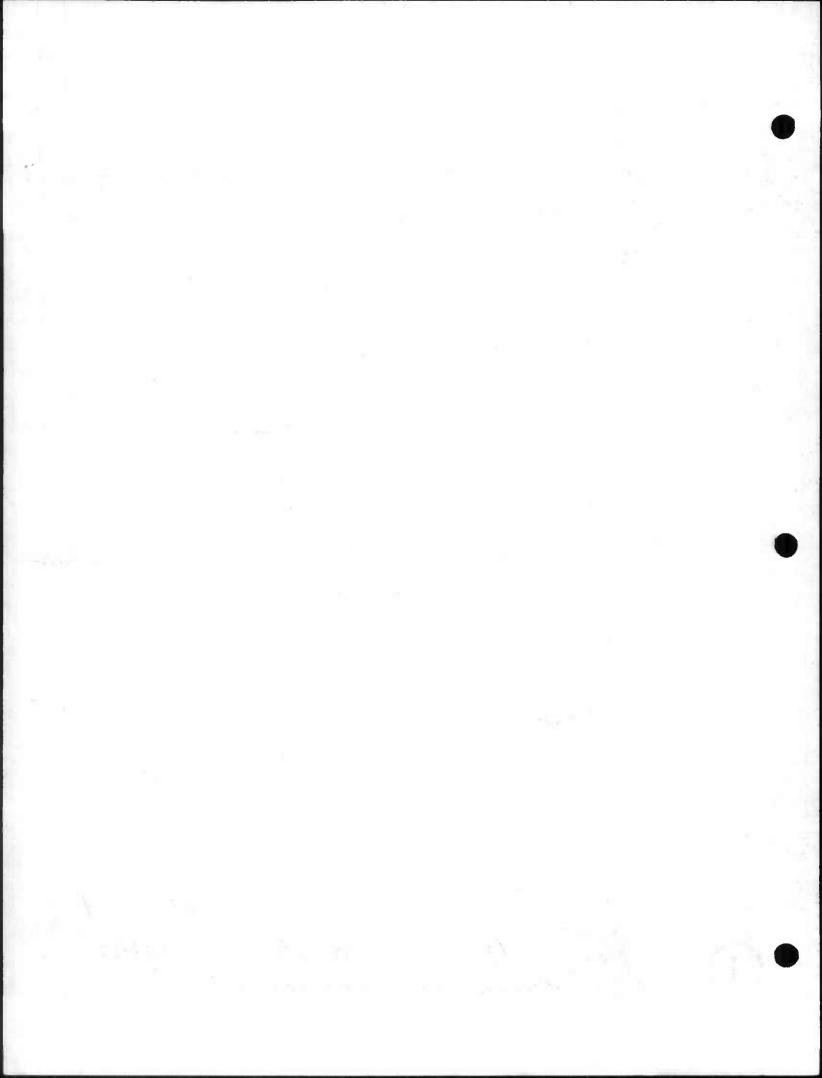
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neral ector	5. Sociel Security Number 217 24 8988	6. Sex 12XIM 2□ F		. last birthday) Yrs.	If Under 1 Yes Months Day		Min. 8. Dat Min. (Mo Sep	a of Birth onth, Day, Y b. 29	(ear) 1930	9. Birthple Counti Mar	aca (Steta or Foreign ry) yland
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any Ir	21. Signature of Funeral Service	oe Licensee	~ 12.00	//	Name and Add				neral		
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State of Maryland / Department of Health and Mental Hygiene 97 2 | 208

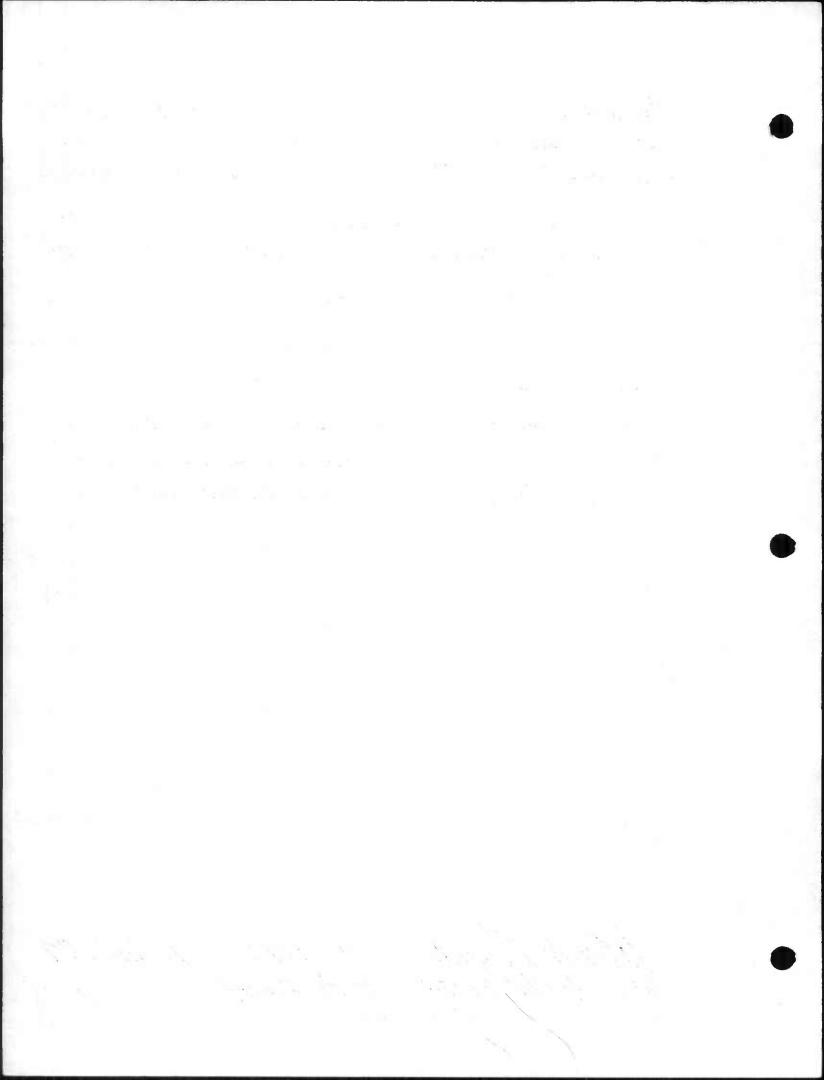
				Ce	rtificate of	Death	Я	eg. No.	
	Dhamiai		Decedent's Neme (First, Middle, Last)				2. Dete of Dee Month		3. Time of Death
	Physici /Medio		Sarah PRICE				June	25 199	
	Examir		4a. Fecility Neme (If not institution, give street end number,	•		4b. City, Town, or L	ocation of Deeth	4c. County of Dec	eth
			Sinai Hospital OF BAL	TIMORE		BALTI	MORE	NA	2
	Funeral Director			ge (In yrs. last birthday) 9 / Yrs.	If Under 1 Year Months Deys		8. Date of Birth (Month, Dey		inthplece (State or Foreign country)  ARYLAND
	and		10a. Stete 10b. County	10c. City, Town or Lo	ocation	4			10d. Inside City Limits
	Many	ō	nod n/12	BALL	imore				1 des 2 No
	the 28s	Director	10e. Street end Number	10 4 -1	10f. Zip Code		1	0g. Citizen of What C	Country?
	With Ba or	Ö	2834FAIRVIEW AVE	2	212			4.51	2
	rrs 2	era	11 Maritel Status 12. Was Decedent		Was Decedent of	Hispenic Origin? (St	pecify Yes or No-	14. Race - Am	ฮ erican Indian.
215-0020	d 2 should be filed within 72 hours efter deeth with the Maryland th end Mental Hygiena. 7 Is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Medical Examinating the notified at	by Funeral	Armed Forces  1 Never Married 2 Married  1 Yes 2 M  1 Yes, Give  Year or Dates:	No	If Yes, specify Cut  1□ Yes 2 No	Hispenic Origin? (Spen, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	
0	2 ho	Pe	15. Decedent's Education	16e. Dece	dent's Usual Occu	pation		16b. Kind of Business	s/Industry
218	hin 7	Completed	(Specify only highest grede completed)  Elementary/Secondary (0₂12) College (1-4or	life.	kind of work done DO NOT use retire	during most of world)	king	_	1-1
2	filed with Hygiena. ther than	P.O.	S The		Home 1	MAKER		DOMES	tie
Pu	be file Ital Hy d othe	Be	17. Father's Name (First, Middle, Last)				ne (First, Middle, i	Maiden Sumame)	AST Name-
Maryland	Mental Mental arked o	10	SAMYEL HALL			ELIZ	A bett	5 - + 4	in Kurwal
an	2 should end Mer s marks sumatic		19e. Informent's Neme/Relationship (Type, Print)	19b. Maili	ng Address (Stree	t end Number or Ru	ral Route Number	City or Town, State,	Zip Code)
Σ	1 end 2 Health em 27 ls		FLORENCE HALL-NEIC	E 314	E. LA	NVALE	STAX	+ 1 BA	Lto. M.d.
ore	S = 0		20e. Method of Disposition	20b. Plece of Dispo	osition (Name of	ace)	Date	20c. Location - City o	r Town, Stete
altimore	0 = 0		1 Burial 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify)	Voscho	566 (5)	auti-	1/10/2	RALL	is Mel
alti	그투원금		21. Signeture of Funeral Service Licensee	2	2. Name and Addr	ess of Fecility	1011	Ball	, md 21213
Ö	Departiment Departiment Important Irraportant	11 min	-	-16391	N. BRO	ACI W #	9-12-01	Jone J SERVICE	
			23a. Part Lint he disease, or complications that cause	the death. Do not en	ter the mode of dv	ing such as cardiac	or respiretory err	JEKIN I	Approximete
	Dhyelelen	108	23a. Part I will the disease, or complications that cause shock or heart failure. List only one cause on each li	ne.	tor the mode of dy	ing, boon as oardiac	or respirotory em	551,	Interval Between Onset end Deeth
	Physician /Medical		Immediete Ceuse (Final	e					, ,
1	Examiner		disease or condition resulting in deeth)						Unhum
		ē		Due to (or es e consec	4				
	betr Insit	Examiner	b. URINAK		INFEC	Tion			
,	exect n and ial-tra	Exa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	Due to (or es e consec	quence ot):				
68760,	icata be executed physicien and s the burial-transit		Cause (Disease or injury that initiated events	Due to for so a seesa					
89	tificate ig phy es the	edlcai	resulting in deeth) Lest	Due to (or es e conseq	quence or):				
Box	attending for use	Z	d						
-	seath cerr attendin d for use	cla	Dort II. Other significant and distance anti-huties to doubt			Deat.	ant mide	4	
P.O.	thet the de ned by the a detached t	Physician/M	Part II. Other algnificent conditions contributing to death b	-					te to the cause of deeth?
	thet bed b	by P	Severe Jehydration				1 Y	es 2 No 3 F	Probably 40 Unknown
Records,	% D C		Non-Insulin Legende		,	11 .	24a. Wes e	n eutopsy 24b.	. Were autopsy findings
8	v require been si should t	Completed	Non-Insulin depende	nt diabet	tes me	llitus	perfor	med?	eveileble prior to completion of cause
Re	has ge 2	d L							of deeth?
a							1 🗆 Y	es 2 No	1 ☐ Yes 2 ☐ No
of Vital	Physician: The this certificate ral director, par	Be C	25. Wes case referred to medical exeminer?  Hospital:			hor	th (Check only or		
o	hy hy	. To	1 ☐ Yes 2 ☑ No ☐ Inpatie  27. Manner of Deeth		III JUA	4 □ Nursing H		ence 6 Other (Special Control of the	ecify)
n	dlng F h. After funer	io	1 Neturel 5 ☐ Pending (Month, De	y Year) 28b. Time o Injury	Wo	ork? ]Yes 2□No	200. Describe no	ow injury occurred	
Division	deetl deetl tor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be	un. At home form at			20f Leasting (C)	troat and Number or F	Qual Paula Number
Š	or A after Dirac in by	i i	determined 200. Flace Of III	ury - At home, farm, str c. <i>(Specify)</i>	reet, ractory, office		City or Town	reet end Number or F n, Stete)	rurer House Number,
	To the Hospital or Attending P within 24 hours after deeth. To the Funeral Director: After to complataly filled in by the funeral		29a. Certifier 154 Certifying Physicien: To the best	of muckenousedness at a second	h 00011880 d =4.444	ima data cod ele	mand along 4 - 44 :	(2) 22.1	a stated
	Fun Fun ataly	edical	29a. Certifier (Check only one)  A  Certifying Physicien: To the best 2  Medical Examiner: On the basis on and menner st and menner st	f examination end/or in	vestigation, in my	opinion, death occur	red et the time, d	euse(s) end menner e ate end place, end du	e to the ceuse(s)
	ithin o the	Med	29b, Signature and the of goulder	acod.	29c. Licen	se number	2	9d. Date signed (Mon	oth, Day, Year)
	FRES		1 /6/1			116			
1	T		199 199		102	1167		6/28/9	/
			30. Name and address of person who completed cause of o	eath (Item 23a) (Type,	Point)	Tree	42.1		r
			31 Date filled (Month Para March)	1838	green	ree	7 500		
	Sta Registr		31. Date filed (Month, 1997 ar)	andell					



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State of Maryland / Department of Health and Mental Hydiene 97 21200

	Item:8	er	FH G-749 7/18/97 dh	State of Mary		parime <i>ertifica</i>			ментал пу	Reg. No.	21209
	Physici		1. Decedent's Neme (First, Middle, Las						2. Dete of De Month		3. Time of Deeth
	/Medi		HARVEY /Th	GE JR	2 .				JULY	11 190	97 8:30 P.M.
	Examir	er	4a. Fecility Neme (If not/institution, give	TCHIE				4b. City, Town, or BALT. T	Location of Deet  IMORE	h 4c. County of E	n/a
-	Funeral		5. Sociel Security Number 6. Se	7. Age (In )	rs lest birthda	y) If Unde	er 1 Year	If Under 24 Hrs		th 12/3 9.	Birthplace (Stete or Foreign
	Director		215-05-6256	<b>D</b> MM 2□ F	/B <sub>/ Yrs.</sub>	Months	Deys	Hours Min	DEC.	th 12/3 9. ay, year, 1918	MARYLAND
	bud ***		Usuel Residence of Decedent  10e. Stete 10b. County	10c.	City, Town or	Location					10d. Inside City Limits
	Merylen H show	tor	MDD n/a		BA	LTIM	ORE				1 🛣 🛣 2 🗆 No
	ath with the Meryle 23a or 28a-f show	Oirec	10e. Street end Number	·		10f. Z	ip Code	010		10g. Citizen of Whe	
	s 23a	rai	3915 CALLOWA					212		UNITED	STATES
020	72 hours effer deeth with the Meryland natural', or items 23a or 28=f show Assal Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Merried 2 Normal American 2 Normal Normal 2 Normal	12. Wes Decedent Ever i Armed Forces? ↓ Yes 2 No if Yes, Give Yeer or Detes:	n U,S. 10	3. Was Deci If Yes, sp 1 ☐ Yes		dispenic Origin? (sen, Mexican, Puer Specify:	Specify Yes or No to Ricen, etc.)	14. Rece - A Black, V Specify:	American Indien, Vhite, etc. BLACK
5-0	72 hours "natural",	eted	15. Decedent's Edu (Specify only highest grad	ucation	16e. Dec	cedent's Us	uel Occup	eation during most of we	nrkina	16b. Kind of Busine	ess/Industry
21215-0020		Completed	Elementery/Secondary (0-12)	College (1-4or 5+)	life	. DO NOT	use retire	ORKER	rkiig	GENERAI	REFRACTORY
	should be filed vand Mentel Hygie marked other turnatic event, m	CO B	17. Fether's Neme (First, Middle, Last)						me (First, Middle	, Meiden Sumeme)	
/lan	Aentei Aentei rked c	To Be	HARVEY PAGE	SR.				S	USIE	BROOKS	
Maryland	C1 0 10 60		19e. Informent's Name/Reletionship (T)	ype, Print)						er, City or Town, Ste	
	1 end Heelth em 27		SYLVIA TURNE 20a. Method of Disposition	ER- NIECE			EGER		Dete Dete	LTIMORE , 20c. Location - City	MD 21215
nor	Peges nent of nrt: If its iry or o		X ⊠ Burial 2 □ Cremetion 3 □ F 4 □ Donation 5 □ Other (Specify)	Jelliovei IIolli Stete	b. Plece of Dis cemetery, co GARRIS		other ple				VINGS MILLS
Baltimore,	permit. Peges 1 e Department of Hee Important: If item any injury or othe		21. Signature of Funeral Service Licens		)	22. Name e	and Addre	ss of Fecility		WABASH	AVENUE
		-	23 Pert1. Enter the disease or comp shock, or heart feilure. List only o	licetions thet caused the d	leeth. Do not e						
	Physician /Medical Examiner	-	Immediate Ceuse (Final disease or condition resulting in death)	e. Jes	olla,	equence of	10	7/100	7		Approximete Intervel Between Onset end Death
Box 68760,	death certificate be executed e ettending physician end nd for use es the buriel-transit	an/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest	c. Due to	o (or es e cons	equence of)	7	rei D/me	r		7 mo
O. B	e death	Physician/M	Pert II. Other eignificant conditions con	ntributing to death but not	resulting In the	underlying	ceuse giv	en In Pert I.	23b. Dld	tobacco uee contrib	oute to the cause of death?
σ.	es that the death cert igned by the ettendin be detached for use	by Phy							1	Yes 2□ No 3[	Probably 412 Unknown
Records,	aw requii is been s 2 should	Completed b				-			24e. Wes	en eutopsy ormed?	4b. Were eutopsy findings available prior to completion of cause of deeth?
	The sate								10	Yes 2000	1 ☐ Yes 2 ☐ No
Vital	Physician: The this certificate ral director, page	Be C	25. Was case referred to medical examiner?  1 ☐ Yes	Hospitel:			Oth	er	eth (Check only	./	lla - aa
of	1 DNeturel 5 Pending (Month, Dey Year) Injury Work?								Residence 6 Other (Specify)		
Division	To the Hospital or Attend within 24 hours efter deeth To the Funeral Director: / completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Pleca ot Injury - A building, etc. (Sp	t home, term,	street, tacto	ory, office		28f. Location ( City or To		r Rurel Route Number,
	To the Hospital or within 24 hours efter to the Funeral Director completely filled in	edicai	29e. Certifier (Check only 2   Medical Exami	sician: To the best of my ner: On the basis of exam end menner steted.	knowledge, de ination end/or	eth occurred Investigation	d et the tir n, in my o	me, dete end plece pinion, deeth occ	e, end due to the urred et the time,	cause(s) end menne dete end place, end	r es steted. due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certiller	1. /	9	29	9c. Licens	e number		29d. Dete signed (M	lonth, Day, Year)
	6 1110		· Mul	MIM	1		D,	130%	2	1200	1/1/97
	( Rhy		30. Name and address of person who or	empleted cause of death (	llem 23a) (Typ	e, Print)	1/1	1 010	1211	T-/ , )	6
	Sta	10	31. Dete filed (Month, Day, Year)	32. Rometrar's St	gnature .	a	476	12/2	040	10hh W.	rayne 1410.
	Registr		JUL 1 4 1997	Sulia Da	vidson-R	ndelle					



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 21210

						Cei	unicai	e oi	Deam			Reg. No.			
	Physici /Medi		1. Decedent's Name (First, Middle, Las Alease	st)		Po	tts				2. Date of De Month July	Day 05	Year 97	3. Time (	of Death 40am
1	Examir		4a. Fecility Nam <i>e (If not institution, give</i> 2922 Parkwood						4b. City, To		ocation of Deatl	h 4c. County			
	Funeral Director			ex □M 2□F XX	7. Age (In yrs. 44	last birthday) Yrs.	If Under Months	1 Year Days		24 Hrs. Min.	8. Date of Bir (Month, Da 09-1	th ly, Year) 9-52	9. Birthpl Count Mo	ace (State	or Foreign
	ha Maryland 28a-f show	ector	Usuel Residence of Decedent  10e. State 10b. County  Md. NA			ty, Town or Lo ltimor	re								City Limits s 2 ☐ No
	23a or	Funeral Director	10e. Street and Number 2922 Parkwood	Avenu	е		10f. Zip	121	5		7.0	10g. Citizen of USA	Whet Count	.ry?	
0200	be filed within 72 hours after daath with the Maryland tel Hyglene. Id other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be netitled at	d by Fune	11. Marital Stetus 1 ☐ Never Married 2 ☐ Marrled 3 ☐ Widowed  ★□Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Yeer or Da	ces? 2.⊈No 9				Hispenic Ori pan, Mexican Specify:		ecify Yes or No Rican, etc.)	14. Rad Bla Specif	ce - Am <i>e</i> rica ck, White, e	etc.	
21215-0020	within 72 h ene. then "natu	Completed by	15. Decedent's Ed (Specify only highest green Elementary/Secondary (0-12)	ucation de completed) College (1- NA	4or 5+)		kind of wo DO NOT us	al Occu ork done se retire	pation during mos ed)	t of work	ing	16b. Kind of B			
Maryland 2	\$ 0 0 ×	To Be Co	17. Fether's Neme (First, Middle, Last)	poral		Labo	orer		18. Mothe		e (First, Middle,	Unempl Maiden Suman			
	faulth a		19a. Informant's Name/Relationship (7  Marilyn Por  20a. Method of Disposition	ter			N. (	Cul	ver S			er, City or Town timore 20c. Location	Ma	ryla	21229 and
Baltimore,	parmit. Pegas 1 and Department of Health Important: if Item 27 any Injury or other tr once.			')	tate	oshell 22	Mer Name en	n .	Garde	ty E	Baltim	-97 Dur ore, M . Nort	aryla	and :	
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	plications that ca one cause on ee	used the deat ich line.			le of dy	ing, such as	cardiac (	or respiratory a		II AV	Approxima Interval Be Onset and	etween
	Examiner	ner	disease or condition resulting in death)	a	Due to (	Or as a conseq	uence of):	2	ANCE						
x 68760,	cartificete be executed nding physician end usa es tha buriel-transit	n/Medicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b		or es e consequer as e consequer		JE.		)					
Box		sician/	Part II. Other significant conditions co	ontributing to dea	ath but not res	sulting In the ur	nderivina c	eus <i>e</i> ai	ven in Part I		23b. Did	tobacco use co	entribute to	the cause	of death?
s, P.0	that the de ned by tha a a dateched i	by Physicia	•									Yes 2 No	3 Prob		Unknown
Records	e law raquires that the deeth hes been signed by tha atta je 2 should ba dateched for	Completed b	~			_					24a. Was	an autopsy omed?	con	re autopsy ilable prior npletion of leath?	r to
ital R	e: The la ificata he or, page		25. Wes case referred to medical						OC Plans	-4 D4	10		1	Yes 2	No
Onor	dung Physicis Ith After this ce Tunaral direct	ation: To Be	examiner?	28a. Dete of (Month	·	ER/Outpatien 28b. Time of Injury		28c. Inju Wo	her: 4 Nu	irsing Ho	me 5 Aesi 28d. Describe		ner (Specify rred	)	
Divisi	To the Hospital or Attend within 24 hours efter death To the Funeral Director: A complately fillad in by the t	Certification:	3 Suicide 6 Could not be determined	building	g, etc. (Specif						City or To				m <i>ber</i> ,
	ne Hospital n 24 hours ne Funeral i plately fillad	edicai	29a. Certifier (Check only one)  Certifying Phy 2 Medical Exam	raician: To the b Iner: On the bas end manne	is of examina	owledge, death ition and/or inv	occurred estigation,	at the ti	me, date an opini <i>on</i> , d <i>e</i> a	d place, a th occurr	and due to the ed at the time,	cause(s) and made, date end place,	anner es sta and due to	ated. the ceuse	(s)
	To the within 2 To the compla	M	29b. Signature end title of certifier	11-	-//-	/(	290	c. Licen	se number	11	_	29d. Date signe	d (Month, L	ay, Year)	7
			30. Name and address of person who	ompleted cause	of death (Item	n 23a) (Type,	Print)	1)	350	4/5		07/	1204	9/	D <sub>n</sub>
			31. Date filed (Month, Day, Year)	THOM	npsoc	J-K	PCIL	AR	25		100 U	EST B	0 7	ราบริเ	N
	Sta	te	.IIII 1 4 1997	Juli	Andre Salans	1- Randel	-								

ITEM; 12 per FH G-750 8-7 State of Maryland / Department of Health and Mental Hygiene 97

PA	UL P.	DEI	LLA-PENNA, JR.			Cei	tificate	of	Death		Reg. No.	•	ion I loss I I
	Physic /Medi		Decedent's Name (First, Middle, La		Peter 1	Della	Penn	a.	Jr.	2. Date of D Month JULY		Year 97	3. Time of Death 5:25 PM
	Exami		4e. Facility Name (II not institution, giv 1400 BONSAL S	re street and number)					4b. City, Town, or BALTIM		th 4c. Count	y of Death	N/A
	Funeral Director		5. Social Security Number  218 - 56 - 1420  Usual Residance of Decedent	APRIL OF F	je (In yrs. last 16	birthday) Yrs.	If Under 1 Months	Year Days		8. Date of B (Month, D April	irth Pay, Year) 7,1951	9. Birthi Cour Mart	place (State or Foreign ntry) Lyland
	r 28a-f show	tor	10a. State 10b. County	N/A	10c. City, T	own or Lo	cation		Baltim	ore City	1		10d. Inside City Limits  1 Yes 2 □ No
	th with the 23a or 28a	al Director	100. Street and Number 1400 Bonsal Stre	et			10f. Zip (	Code	21	224	10g. Citizen of United		
020	hours after death with the Maryland ural; or flems 23a or 28a-f show il Examiner must be notified at	by Funeral	11. Maritel Stetus  1 Never Married 2 Married  3 Widowed 4 XDivorced	12. Was Decedent Armed Forces? 1 [A Yes 25] If Yes, Give Year or Dates:	No				Hispenic Origin? (sean, Mexicen, Puer Specify:	Specify Yes or N to Rican, etc.)	o- 14. Ra Bla Specii	ck, White,	can Indian, etc. Thite
and 21215-0020	ad within 72 ho rgisins. er than "natur t, the Medical	Completed	15. Decedent's E (Specify only highest gra Elamantary/Secondary (0-12) 10 Years	Collaga (1-4or		(Give life. L	lent's Usual kind of work DO NOT use ILE SA	done retire	duning most of wo	orking	16b. Kind of E		
yland	Western H	To Be (	17. Father's Name (First, Middle, Last, Paul Peter Della		r.					me (First, Middle TNA WTZ	e, Maidan Sumai		
e, Mar	$W_{i}$		19a. Informant's Name/Relationship ( Margaret A. Joyo			709	Hawkr	idg	e Drive	Hambur	g, PA 1	9526	
timop	Page on and bary of de		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specification)	y)		Lawn	sition (Name natory or oth Cemet	ery	1 7/14/1	997	20c. Location  Baltin	nore.	Maryland
Bal	Departiment Important Impo		21. Signeture of Funeral Service Moe			Du 79	Name end Ida-Ru 122 Wi	Addre CR Se	ess of Facility Funeral Ave. Du	Home of	Dundalk Marulano	2, Inc	c. 222
	Physician		23a. Pan 1. Enter the disease, or com shock, or haart failure. List only			Do not ente	er the mode	of dyi	ng, such es cardia	c or respiratory	arrest,		Approximete Interval Batween Onset end Death
	/Medical Examiner	Je.	Immediate Ceuse (Final disease or condition rasulting in death)	a Perfus	Due to (or as	-conseq	uence of):	Yu	edend)	(Men)			
ó	a executed an and rriel-transit	Examiner	Sequentially list conditions, if eny, leading to immediate causa. Entar Undarlying Causa (Disaasa or Injury that initiated events  Due to (or as a consequence of):  Due to (or as a consequence of):									•	
ox 68760,	eath certificate be executed attending physician and for use es the buriel-transit	√Medicai	Causa (Disaasa or Injury that initiated events resulting in daath) Last	d	Due to (or as	e consequ	uence of):						
s, P.O. Box	thet the died by the detached	by Physician/	Part II. Other algnificant conditions of	ontributing to death b	ut not resultin	g in the ur	derlying cer	use gi	ven in Part I.		I tobacco use co Yes 2□ No		o the cause of death? bably 4000nknown
Records,	e law requir hes been s ge 2 should	Completed b	Appertension							peri	s an autopsy formed?	av	ere autopsy findings ailable prior to impletion of cause death?
Vital	iclan: The k certificate he rector, page	ပိ	25. Was case referred to medical				_				Yes 2□No	1/8	Yes 2 No
>	Physician: 'this certifice	To Be	examiner?  1 X Yes 2 No	Hospital:	ent 2 ER/	Outnation	3 DOA	Otl		ath (Check only	one) idence 6 □Ott	nor /C==="	6d)
ion of	Attending Physist death.  •ctor: After this c by the funeral dis		27. Manner of Death  1. Natural 5 Panding 2 Accidant invastigation	28a. Date of Inju (Month, Da	ry 28	b. Time of Injury		c. Inju Wo	4 Li Nursing i		how injury occur		V)
Division	or Attending F effer death. Director: After d in by the funer	ertification:	3 Sulcide 6 Could not be determined	28e. Place of Inj building, at	ury - At home c. (Specify)	, farm, stre	et, factory,	office			(Street and Number, State)	ber or Rura	al Route Number,

29a. Certifiar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E.

JULY 10,1997

30. Name end address of parson ocompleted cause of daeth (Item 23a) (Type, Print)

Chute no 31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

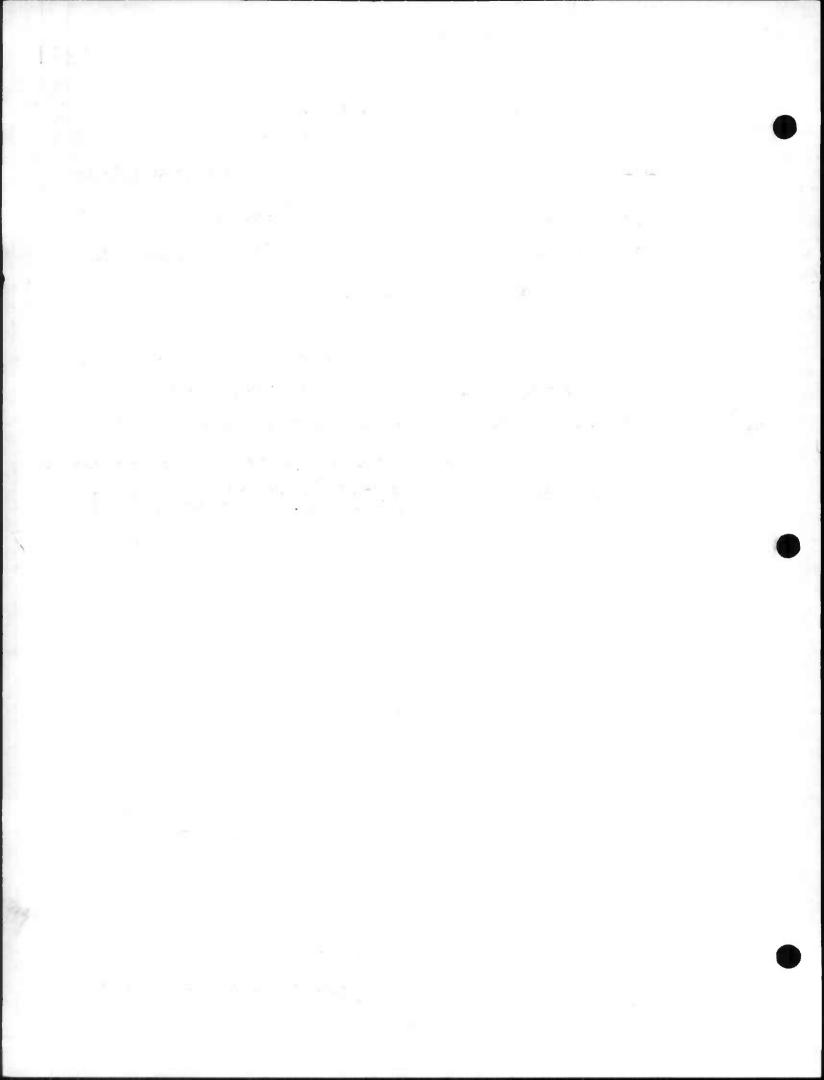


To the Hospital or Attending Physician: The law requires that the within 24 hours etter death.

To the Funeral Director: After this certificate hes been signed by the

completely filled in by the funeral director,

Medical Certification: To



Physic /Med Exam

Funera Director

with the Maryland 23a or 28a-f show ust be notified at

Baltimore, Maryland 21218

permit. Peges 1 and 2 should be filled with Department of Health and Mental Hygiens, Important: If item 27 is marked other than any Injury or other treumatic event, the M office.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requiras that the death certificate be executed within 24 hours effer deeth.

To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be datached for use as the buriel-trensit

Division of Vital Records, P.O. Box 68760.

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

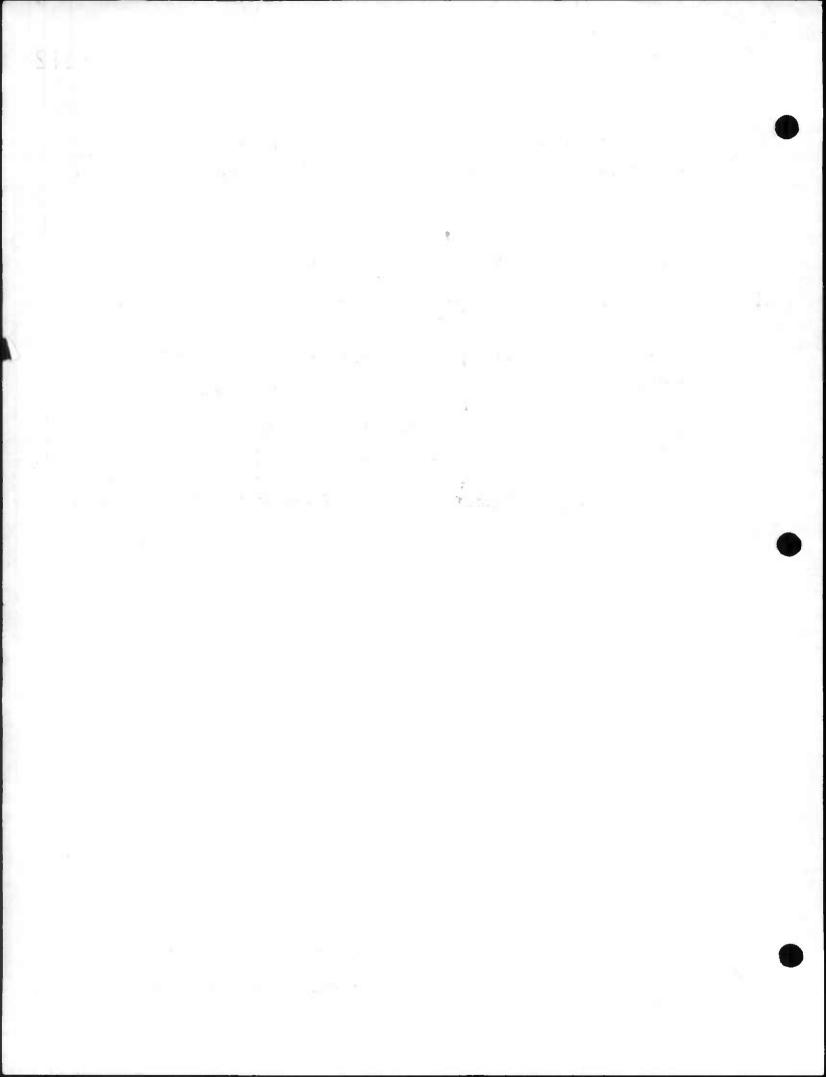
KA	State of Maryla		artment of F rtificate of				iene 9	7 2	21212
	Decedent's Name (First, Middle, Last)				T	2. Date of Deat	h		3. Time of Death
ian	ALONZO RAY SR					Month JULY 0	9. 19	Year 9.7	2235PM
cal ner	4e. Fecility Name (If not institution, give street end number)			b. City, To		cation of Deeth	4c. County		2200111
	UNIVERSITY HOSPITAL E.R.			BALT	IMOR	E CITY	N	/ 2	
		rs. lest birthdey)		If Under Hours		8. Date of Birth (Month, Dey,	***	9. Birthpl	lece (Stete or Foreign
	216-50-4917 <sup>1</sup> ₹M <sup>2□</sup> F 49	Yrs.	Months Days	Hours		JUNE 2	3, 194	Couini 18	NC
	Usuel Residence of Decedent  10a. State 10b. County 10c.	City Town and a	antine.						
5		City, Town or Lo						10	0d. Inside City Limits  17☑ Yes 2 ☐ No
ecto	14/11		BALTO	)					71
ត់	10e. Street end Number	*	10f. Zip Code			1	0g. Citizen of V	Whet Coun	try?
eral	1312 N. KENWOOD AVE	110 401	212		1 1-0 (0		U.S.	A e - America	an India
ü	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married	10,5.	Was Decedent of H f Yes, specify Cuba	in, Mexica	n, Puerto F	Rican, etc.)	Blac	e - Amenci k, White, e	an Indian, etc.
oy.	3 ☐ Widowed 4 ☑ Divorced If Yes, Give 196	, ,	I□Yes 2√ No	Specify.	:		Specify	BLA	CK
Completed by Funeral Director	15. Decedent's Education	16e, Deced	lent's Usuel Occup	etion		-	16b. Kind of Bu		
plet	(Specify only highest grede completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done	during mos	at of workin	g			,
EO	12th N/A		MECHANI				AUTO	SHOP	
Be	17. Father's Name (First, Middle, Lest)		TIPOTIMIA I		er's Name	(First, Middle, I			
10	JAMES RAY SR			P	NNA	STUBB	5		
	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street	e <i>nd Nu</i> mb	er or Rural	Route Number	City or Town,	Stete, Zip	Code)
	LYNN DIXON	3531	ELMORA	AVE	BAT		2121	3	
		<ul> <li>Plece of Dispo</li> </ul>	sition (Neme of netory or other place		TI	Date JL 15	20c. Location -	City or To	wn, Stete
	1 Suriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify)	ARRISO	N FORES	T VA			WINGS	мт	LLS, MD
	21. Signature of Funeral Service Licensee	22	. Name end Addre	ss of Facili	ВЕТТ	S FUNI	ERAL H	OME	DUS, ND
	Hata Barte	11	29 N. C	AROL	INE	ST BAI	TO. M	D 21	213
	23a. Pert1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.								Approximate
	shock, or near failure. List only one cause on each line.		^						Intervel Between Onset end Death
1	Immediate Ceuse (Final disease or condition	448	Disor	0.					
	resulting in death) a.	(or es e conseq	-					-	
Examiner									
Eam	Sequentielly list conditions,	(or es e conseq	uence of):						
E	Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury								
dlcai		(or es e consequ	uence of):						
Physician/Me	d							i	
ian								i i	
ysle	Part II. Other eignificent conditione contributing to death but not r	esulting In the ur	nderlying cause giv	en in Pert	l.	23b. Did to		ntribute to	the cause of death?
4 P						1 🗆 Y	S PENO	3 Prob	eably 4 Unknown
d by						24a. Wes e	n eutopsy	24b. We	ere eutopsy findings
Completed						perform		eve	eileble prior to apletion of cause
d L						.54.			deeth?
Ö	OF Was seen referred to madient					1/583/		102	Kes 2□ No
o Be	25. Was case referred to medical exeminer?  1 □ Yes 2 □ No Hospital: 1 □ Inpatient 2	(Victoria)	Oth	er _		(Check only on			
To To	27. Manper of Deeth 28e. Dete of Injury	28b. Time of	T 3LI DOA	4 L N		ne 5 🗆 Reside 8d. Describe ho			")
tior	1 Maturel 5 Pending (Month, Dey Yeer) 2 Accident Investigation	Injury	28c. Injur Wor	k? Yes 2□					
fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At	home, farm, stre				8f. Location (St	reet end Numb	er or Rure	i Route Number,
Certification:	4 ☐ Homicide determined building, etc. (Spe	cify)	, , , , , , , , , , , , , , , , , , , ,			City or Town	, State)		
	29a. Certifier 1□ Certifying Physicien: To the best of my k	nowledge, death	occurred at the tin	ne, date er	nd plece, e	nd due to the co	ouse(s) end ma	nner es st	eted.
Medical	(Check only one) 2 Medical Examiner: On the besis of examiner end menner stated.	netion end/or Inv	estigetion, in my o	pinion, dee	th occurre	d et the time, d	ate end place,	end due to	the ceuse(s)
Me	29b. Signature and fittle of certifier		29c. Licens	e number		2	9d. Dete signe	d (Month, I	Dey, Year)
	Nonna O Church no		o.c.	ΜĒ			TITEV	1.0	1007
Į.	30. Name end eddress of person why completed cause of death (It	em 23e) (Type. I		rī.E.			JULY	10,	177/
	Dennis J. Chute 10		•	reet	. Ba	altimo	ce. Ma	rvla	nd 21201
te	31. Date filed (Month, Day, Year) 32. Registrer's Sig				,				

State Registrar

141997

32. Registrer's Signature

Son-Randell



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 3. Tima of Death 2. Data of Death **Physician** Day DALLAS RENNER, SR. TI Month OLIN 8:30 AM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore **Examiner** Saint Joseph Medical Center Towson If Undar 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Numbar 8. Date of Birth (Month, Day, Year) NOV. 26, 1908 7. Aga (In yrs. last birthdey) Birthplace (Stata or Foraign Country). **Funeral** Days 1 XM 2 □ F Director 213-05-8082 88 Virgînia Usual Rasidanca of Dacedant the Meryland 10b. County 10a. Stata 10c. City, Town or Location 10d. Insida City Limits permit. Peges 1 and 2 should be filed within 72 hours efter death with the Merylai Deportment of Heelib and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 23a-f show any Injury or other traumatic event, if a Medical Examiner mant be notified a 28a-f show 1 ☐ Yas 2X No Director MD Baltimore White Hall 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21161 19641 Graystone Rd. U.S.A. Funeral 12. Was Dacedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ② No If Yas, Giva Yeer or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Race - Amarican Indian, Bleck, Whita, atc. 1 Navar Married 2 Marriad Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: White by 3 X Widowad 4 □ Divorced Completed 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grade complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Machinist 8 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Surnama) Be Rosa Beatley James Renner 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Streat and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda) 1201 Haven Wood Rd., Baltimore, MD 21218 Dallas O. Renner, Jr./Son 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition July 7, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Ramoval from State Towson, MD Prospect Hill Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 1997 21. Signature of Funaral Service Licenses 22. Nama and Addrass of Facility J.J. Hartenstein Mortuary, Inc. druk 24 Second St., New Freedom, PA 17349 23a. Part1. Efter tha disaase, or complishock, or heart failure. List only or id the death. Do not anter the moda of dying, such as cerdiac or raspiratory arrast, Approximeta Intarval Batween Onsat and Daath **Physician** RESPIRATORY INSUFFICIENCY /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of): Examiner PULMONARY EDEMA AND HEMORRHAGE buriel-trensit Sequantially list conditions, if any, laading to immadiata ceuse. Enter Undarlying Cause (Diseasa or Injury that initiated avants rasulting in daath) Last pue Due to (or as a consequence of): P.O. Box 68760, ettending physician 2 Physician/Medical the The lew requires that the death certificate Dua to (or as a consequence of) 98 esn 5 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. deteched 23b. Did tobacco use contribute to the cause of death? 100 been signed by should be detec THROMBOCYTOPENIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Records, þ 24b. Wara autopsy findings eveilable prior to complation of causa of daeth? 24a. Was an autopsy performad? Completed MYELODYSPLASIA has page 2 Yas 2 No certificate Division of Vital the Hospital or Attending Physician: nin 24 hours efter death. Be 25. Was case rafarred to medical 26. Placa of Daath (Check only one) Hospital: 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funerel 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred Medical Certification: 28h. Time of 28c. Injury at Work? After 1 Natural 5 Panding invastigation 1 Yas 2 No 2 Accidant **Director:** in by the 3 Suicida 6 ☐ Could not be detarmined 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide To the Hospital o within 24 hours eff To the Funeral DI completely filled in tion Certifying Physician: To the best of my knowledge, daath occurred at tha time, date and place, and due to the causa(s) and manner as stated.

2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifiar (Check only 29b. Signature and title of certified 29c. Licensa number 29d. Date signed (Month, Dav. Yaer) 13140 . M.D and address of person who complated causa of daath (Item 23a) (Typa, Print)

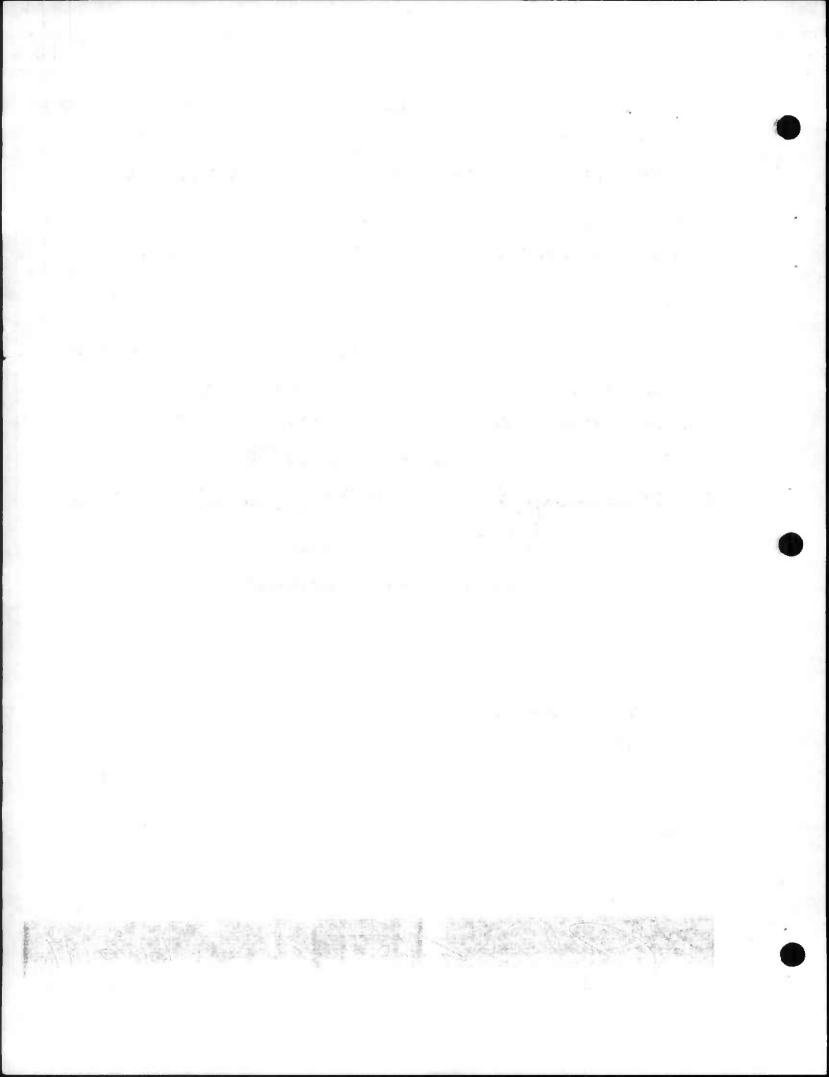
State Registrar 31. Date filed (Month, Day, Year) 14 1997

REYNALDO ORJUBLA-GOMEZ,

32. Ragistrar's Signatura

whia Davidson

M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204



O.C.M.E.

JUNE 21,1997

111 Penn Street, Baltimore, Maryland 21201

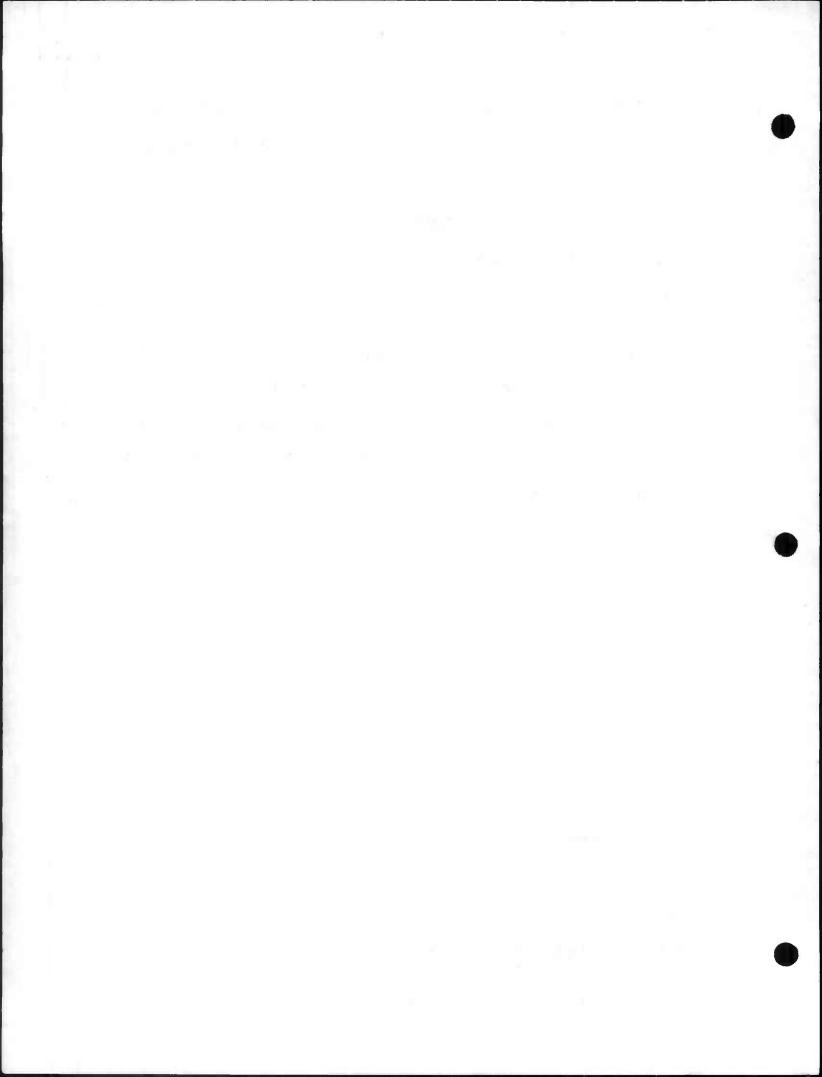
To the Hospital within 24 hours to the Funeral Completely filled

State Registrar Stephen

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Radent?

**DHMH 16 Rev 6/95** 



97-3758-510 wlc LILLIAN

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

July 9, 1997

9	7	2	0	1	£
7	1	4	2		-

3. Time of Deeth

q00:8

Par 2 No

**Physician** /Medical

**Funeral** 

RIECH

the Maryla

**Examiner** 

Director MESa or 28a-f show Director Funeral ρ

the Medical poemit. Pages 1 and 2 should be file.
Department of Heath and Mental Hy, important: If New 27 is marked other any Injury or other.

Baltimore, Maryland 21215-003

**Physician** /Medical Examiner

The law requires that the death certificete be executed buriel-transit pue ettending physician the 50 ed by the e signed b peen hes pege 2 After this certificate To the Hospital or Attending Physician: within 24 hours efter death. by the Director: within 24 hours efter To the Funeral Direc completely filled in by

P.O. Box 68760.

Division of Vital Records.

Completed Be disease or condition resulting in death) Physician/Medical by Be Completed Medical Certification: To 27. Menner of Deeth 1 Neturel 2 Accident 3 Suicide 4 Homicide 29a, Certifier

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Yeer LILLIAN MAY REICH 8,1997 July 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 3406 MT PLEASANT AVENUE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Devs Hours Min. (Month, Dey, 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) Yeer) 1 M 2 F Months 79 Yrs. Maryland 217-01-2080 1917 Usual Residence of Decedent 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3406 Mt. Pleasant Avenue 21224 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3/□ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Medical 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) John Moerschel Elizabeth Schmidt 19e. informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mrs. Karen E. Zukas, daughter 1510 Singer Road, Joppa, Md. 21085 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Oak Lawn Cemetery 7-11-97 Baltimore, Md. 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Matthews Funeral Home 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest,

Apr. shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth . Hypertensive Atheroscleronic Cardibuscular Immediate Ceuse (Finel d. 3 ease Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequença of): Due to (or es e consequenca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 分 nknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 PNo 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and manner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer)

State Registrar

111 Penn Street, Baltimore, Maryland 21201

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

O.C.M.E.

- A 

B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

TIMOTHY JOHN RIGGIN

State of Maryland / Department of Health and Mental Hygiene 97

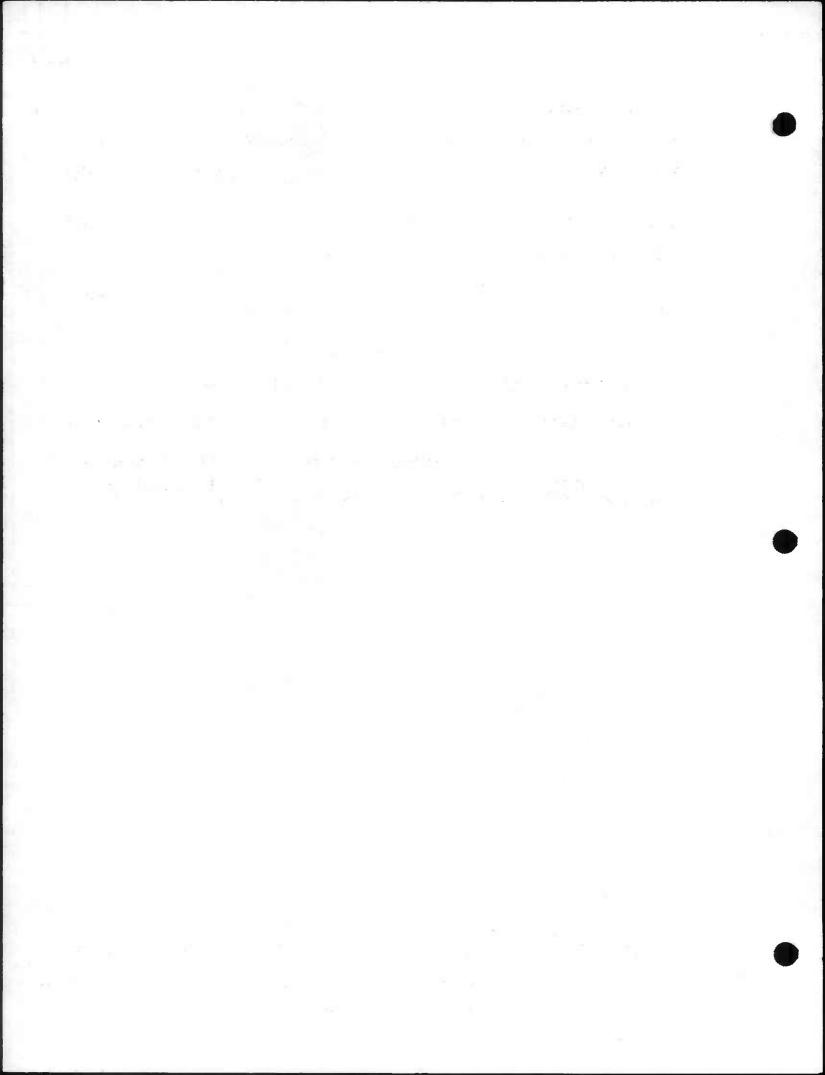
21216

Items:	23a	part I,27,28a-f per MEO	G-749 7/18/97 dh	Cer	tificate of	Death		Reg. No.			
Division		1. Decedent's Name (First, Middle, Last)				2. Date of Death 3. Time of Dea			3. Time of Death		
Physician /Medical Examiner		I HIDERY JOHN RIGGIN					JULY	10, 1	Year L997	0859AM	
		4e. Fecility Neme (If not institution, give	street and number)			4b. City, Town, or L	ocation of Deatl			1.00	
		117 PATRICIA AVENUE LINTHIC					CUM	ANNE	E ARU	INDEL	
Funer	al	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days									
Directo	or	220 70 1616 1⊠M 2□F 40			Yrs. Augus			t 15,1956 Maryland			
9		Usual Residence of Decadent  10a. State 10b. County	10c Ci	ty, Town or Loc	ation				10	ed Impide City I imite	
faryta.	5			Linthic					10	d. Inside City Limits  1 ☐ Yes 2 ☑ No	
the A	ect	Maryland Anne Arundel Linthicum  10e. Street and Number						10g. Citizen of What Country?			
020  urs after death with the Maryland sir, or items 23s or 28s-f show Examiner must be notified at	ᅙ	117 Patricia Ave	10f. Zip Code 21090				U.S.				
	Funeral Director	11. Marital Status				acifu Vae or No		e - America	n Indian		
5 £ £	듄	11. Marital Status  1 ☐ Never Married  1 ☐ Never Married  1 ☐ Was Decedent Ever In Armed Forces?  1 ☐ Yes 2 ☑ No		If Yes, specify Cuban, Mexican, Puert		Rican, etc.)		Black, White, etc.			
0020 hours after ursif, or the al Examine	by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:				Specify: White			
O of man			15. Decedent's Education			16a. Decedent's Usual Occupation			16b. Kind of Business/Industry		
	Completed	(Specify only highest grede completed)  Elementary/Secondary (0-12)  College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  Driver			ing				
<b>部。</b>	\   E						Truck		cking		
P NEED BE	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Sumem	10)		
4 4 4 4	T of	Jo	ohn A. Riggin			Be	etty J.	Salley			
Mary d 2 sho th and N 7 is man trauman	Ι'	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailing	Address (Stree	t and Number or Rur	al Route Number	er, City or Town,	Stete, Zip (	Code)	
CSNL		John Riggin /	Father	117 P	atricia	Avenue	Linthi	icum, Ma	rylan	d 21090	
		20a. Method of Disposition  1 🖾 Burial 2 🗆 Cremetion 3 🗆 F		Placa of Dispos cemetery, crem	ition (Name of atory or other ple	ece)	Date	20c. Location -	City or Tow	vn, State	
a de tit de		4 Donation 5 Other (Specify)	Me	adowrid	ge Memo	rial Park	7/14/9	7 Balti	more,	Maryland	
permit. Page Department of Important: If important: If	ti di	21. Signature of Funeral Service Licens	00	1 22.	Name end Addr	ess of Facility	Gonce F	uneral	Home	P.A.	
0 8052	84	Olymn Z	an in and	40	01 Ritch	nie Highwa					
		23a. Part1. Enter the disease or compleshock, or heart failure list only of	ications that caused the deet							Approximete Interval Between	
Physicia	n		TO DESCRIPTION OF THE PROPERTY							Onset and Death	
/Medica		Immediate Cause (Final disease or condition MULTIPLE DRUG AND ALCOHOL INTOXICATION									
Examine		resulting in death)	a. MULTIPLE DRUG AND ALCOHOL INTOXICATION  Due to (or as a consequence of):								
D #	la la										
ertificete be axecuted sing physician end a as the burial-transit	Examiner	Sequentially list conditions,	Due to (d	or as e consequ	uence of):						
cian cian		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events									
ifficete be axe g physician e as the burial-	/Medical	thet Initiated events resulting in death) Last	Due to (c	or as a consequ	ence of):						
entific ding p											
deeth certificate to attending physical deforuse as the best for use as the best for the best fo	lan										
	Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to							ntribute to	the causa of death?	
thet the							1 Yes 2 No 3 Probably 4 Unknow				
0 00	d by					24a. Was an autopsy 24b. Were eutopsy findin			o autonov findings		
	Completed						ormed? aveilable prior to completion of cause				
D & S S	l d									eeth?	
- F # 6							1/X	Yes 2□No	1/0	Yes 2□ No	
Physician: The This certificate rel director, per	Be	25. Was case referred to medical examiner?	Acenital:		0	26. Place of Deat	h (Check only o	nne)			
this eldi	10	3625 S 140		ER/Outpatient	3LI DOA			denca 6 □Oth		)	
Affer funer	Certification:	27. Manner of Deeth  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		28d. Describe i	now injury occurr	red		
	Cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	found 7/10/97				subject ingested drugs and alcohol				
i or Attendatian din by the	Ī	4 ☐ Homicide determined	28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State) 117 Patricia Ave.,					
Hospitai 24 hours Funerai taiy filled		home Linthicum, Md.									
To the Hospital or within 24 hours affer To the Funeral Director completaly filled in	edical	29e. Certifier. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examinat: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.									
To the To the comple	¥ 6	29b. Signatura and title of certifier	and manner stated.		29c. Licen						
⊢ ≯ F ŏ		VAG. 10 MA			O.C.M.E			29d. Date signed (Month, Day, Year)  JULY 11, 1997			
f		Queut	arong	/				0011			
		30. Name and address of person who co	empleted cause of death (Item							0.4.0.7	
	4 - 4	31. Date filed (Month, Day, Year)	De Carrello Di es	4-1		et, Balt	ımore,	Maryl	and	21201	
S Regis	tate	31. Date filed (Month, Day, Year) 1 4 1997	July Davidson	72	¥						
ricgis	Arui		0 WINGON	-Mande							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97

				Otate of Mi	aryland		Certifica			Meritarriy	Reg. No.	1 6	1211
			1. Decedent's Name (First, Middle, La	st)						2. Date of De	eath		3. Time of Death
	Physici /Medic		JANE MAI	EYER S	IM	250	N			Month	Day	q q 7	926/pm
	Examir		4a. Facility Name (If not institution, giv					4	b. City, Town, or	Location of Deal			
			THE UNION ME	EMORIAL	110	[92	TAL	_	BALTI	MORE		N/A	
	Funeral		Social Sacurity Number     6. S	ax 7. Ag	e (In yrs. le	st birtho	(ay) If Und	dar 1 Year	If Under 24 Hrs Hours Min	8. Data of Bi	rth		ce (State or Foreign
	Director			I M 2√√F	81	Yrs	3. Monte	is Days	Hours Min	8. Data of Bi (Month, D August	0,1915	Pennsy	lvania
	D .		Usual Residence of Decedent  10a. State 10b. County		100 City	Tour	r Location					140	
	aho aho at at	70	The second second		Too. Oily							100	d. Inside City Limits
	the N	Director	Maryland N/A  10e. Street and Number			Ba	altimo				40 000 11		Ves 2□No
	sth with the Maryland 23a or 28a-f show vat be notified at		4100 N Charles	C+			101.	Zlp Code 2121	0		10g. Citizen of		y?
	na 23	era	11. Marital Status	12. Was Decedent	Ever in 11 9		13 Was De			Enacify Vac or N	US	A Amaricar	Indian
000		by Funeral	1 Never Married 2 Married  X3(X)Widowed 4 Divorced	Armed Forces?  1  Yes 2 V					ispanic Origin? (9 nn, Maxican, Puer Specify:	to Rican, etc.)	Bla Specifi	ck, White, et	
		Completed	15. Decedent's Ed (Specify only highest gra	ide completed)		16a. D	ecedent's U	sual Occupa work done of	ation during most of wo	rking	16b. Kind of B	uainess/Indu	stry
213	1111	ошь	Elementary/Secondary (0-12)	College (1-4or 5	5+)	,,,		maker			Ow	n Home	2
	Hyg offher rent,	Be C	17. Fathar's Nama (First, Middle, Last,	1						me (First, Middle	, Meidan Sumer	-	
la a	About Monta	To B	Horace Chayne N	1aeyer					Edith	Miller			
Maryland	and ha	-	19a. Intormant's Name/Relationship (	Type, Print)		19b. N	tailing Addre	ess (Street	en <i>d Number</i> or R	ural Routa Numb	ar, City or Town,	Stete, Zip C	code)
	and 2 saith i s 27 is er tre		Jane Ann Simpson	n Da	ughte	r 7	769 E.	Main	St Purc	ellvill	e, Virgi	nia 20	0132
ore	ges 1 and 2 should it of Health and Me if Hem 27 is merke or other traumetic		20a. Mathod of Disposition 1 ☐ Burlal ※XXCremation 3 ☐	10	20b. Pla	ace of D	isposition (A	Verne of or othar plea	e)	Date	20c. Location	City or Tow	n, State
Ĕ	Pages nent of ant: If the		4 Donation 5 Other (Specif	y)	Gre	enmo	ount C	emete	ry	7/15/97	Baltimo	re, M/	ARYLAND
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 eny injury or other to otice.		21. Signature of Funeral Service Light	Isea /					ss of Facility Mi	tchell-	Wiedefel	d Home	9
			23a Part 1 Enter the disease or com	plications that causes	the death	Do not	6500	York	Road Bal	timore,	Marylan		12 Approximate
6	Physician		23a. Part1. Enter the disease, or com shock, or heart tailure. List only	one cause on each li	ne.	DOTIO	Onto the m	oue or ayiii	y, audit as cerdia	c or respiratory a	illosi,	10	nterval Between Onset and Death
λ.	/Medical		Immediate Cause (Final	00.12	>C A	ø ()	7 A (	7	FARCT	CANT		1	Hour
	Examiner		disease or condition resulting in death)	a. 14 CYC		55 11			) FIFE	TOIO			LHOCK
		ner			10) 01 800	as a cor	nsequence o	ory.				1	
	ifficate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions.	b. ————	Dua to (or	as a cor	nsaguance c	of):					
ó	e exe lan ar		Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying					,					
68760,	hysic hysic	edical	Cause (Disease or injury that initiated events rasulting in death) Last	C. ————	Dua to (or	as a con	sequance o	f):					
	ing p			4									
80	ath co	lan/		d								1	
o	the e	Physician/N	Part II. Other significant conditions of	ontributing to death be	ut not resul	ting in th	a underlying	g ceuse giv	en in Part I.	23b. Did	tobacco use co	ntribute to t	he cause of death?
Division of Vital Records, P.O. Box	The law requires that the deeth cartificate been signed by the ettending page 2 should be deteched for use a									1□	Yes 2□ No	3 Proba	bly 4 Unknown
ds	w requires thei been signed I should be det	d by								24a Was	an autopsy	24b. Were	autopsy tindings
00	v requestions	lete								perf	ormed?	com	able prior to pletion of ceuse
Re	e lav	Completed								4.0	· · · ·		iath?
a	sicien: The law certificate hes b director, pege 2 s		25. Was cese raferred to medicel						OC Place of Do		Yes 2 DKNo	10'	Yes 2 No
>	ysician: The la is certificate he director, page	To Be	examiner? 1 □ Yas 2 ☒ No	Hospital:	int obde	R/Outpa	atlent 3	DOA Oth	or:	ath (Check only	one <i>)</i> Idence 6 □Oth	ar (Spacifu)	
0	Attending Physician: or death. ector: After this certific. by the funeral director,		27. Manner of Death	28a. Date of Injur	ry :	28b. Tim	e ot	28c. Injun World			how injury occur		
0	ttending death. ctor: Afte y the fun	atlo	1. Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	y Year)	Inju	ry M		Yas 2□No				
N N	l or Attending Phiefer death.  Director: After this in by the funeral	Certification:	3 Suicide 6 Could not be determined	28a. Place of Inju	ury - At hor	na, ferm	, street, tact	ory, office			Street and Numl	per or Rural I	Route Number,
Ō	rs efter or all Oliver or in ed in	Cer		building, oc	o. (Opeony)					Oily or to	m, olatoj		
	To the Hospital or Att within 24 hours efter of To the Funeral Direct completely filled in by	edical	29a. Cartifiar (Check only one) Certifying Ph	ysician: To the bast on niner: On the basis of and manner sta	examination	iedge, d on and/o	eath occurre r investigati	ed at the tim on, in my op	ne, date and place pinlon, death occ	e, and dua to the urred at the time,	cause(s) and modate and place,	enner as stat and due to ti	ed. ha causa(s)
	vithir To th	Me	29b. Signatura and title of certifiar	211			2	29c. Licansi	a number		29d. Data signe	d (Month, De	ay, Year)
			1/ dow 2	Hill, M	0			D41	699		July	9,190	77
	3	ŀ	30. Name and address of person who	completed ceuse of d	eath (Item	23a) (Ty				ILL, M	. D.	1 , ,	
			M3M GOZMU SHT									INORE	MD ZIZIS
	Sta Registra		31. Date tiled (Month, Day, Yeer) JUL 1 4 1997	Filter D							t		



State of Maryland / Department of Health and Mental Hygiene 97 2 | 2

					(	Certificate	of i	Death		Reg. No.		
	Diam'r.		1. Decedent's Name (First, Middle, L	ast)					2. Dete of De		Voor	3. Time of Death
	Physic /Medi		CELLA SCOT	T					Jul	1 10 1	1997	650 PM
	Exami		4e. Facility Neme (If not institution, g	ive street end number)			4	lb. City, Town, or L			y of Deeth	
			JUNAY HOS	PITAL OF	BANT	INDRE		DAG	TIMEDE	5	NA	
	Funeral				yrs. last birth	Months	1 Year Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, De			oce (State or Foreign
	Director		231-60-1140	1□ M 2 x F 7	5 Y	rs.			12-21		VA	
	and w		Usuel Residence of Decedent  10e. State 10b. County	10	c. City, Town	or Location					10	d. Inside City Limits
	sho	5	Md. NA		•	imore						1 ∑ Xes 2 □ No
	h the Maryland r 28a-f show	ect	10e. Street and Number		Daic	10f. Zip (	Cada			10a Citizan of	Mhat Causti	
	23a or	ä	4615 Park Hei	ahte Avonu		1 .	121!	=		10g. Citizen of		yr.
	death with the Maryland ms 23a or 28a-f show	<b>Funeral Director</b>	11. Marital Status	12. Was Decedent Ever					posific Von as No	US.	A ce - Americar	n Indian
	ter dea	F	1 Never Married 2 Married	Armed Forces?	W 0,5.	If Yes, speci	ify Cuba	ispenic Origin? (Sp in, Mexican, Puerto	Rican, etc.)	Bla	ck, White, et	
20	hours efter tural, or ite	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Detes:		1 □ Yes 2	ŬNo.	Specify:		Specif	y: Bla	ck
21215-0020	72 hours "natural", edical Ext		15. Decedent's I	Education	16a. [	Decedent's Usuel	Occup	etion		16b. Kind of B		
215		Completed	(Specify only highest g Elementery/Secondary (0-12)	rade completed)  College (1-4or 5+)		Give kind of world life. DO NOT use	k done d e retired	etion du <i>ring</i> most of worl f)	king			
	il Hygiene. other than	E O	9th Grade	NA.	Н	ome-mak	er			in H	OMA	
pu	e filed el Hygi other vent, I	Be	17. Father's Name (First, Middle, Las					18. Mother's Nam	ne (First, Middle			
Va	Ment Ment rked	To	John R. Bu	rkley				Este			Mitc	hell
Maryland	s 1 end 2 should be filed withing Hygiene. If Health and Mentel Hygiene. Item 27 is marked other than other traumatic event, Ina.M.		19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address	(Street	end Number or Ru	rel Route Numb	er, City or Town	, Stete, Zip C	<sup>Code)</sup> 21218
	of Health Item 27 other tr		James Sco			2815 Ki	rk	Avenue		imore 20c. Location		
ore			20e. Method of Disposition  X□XBurial 2 □ Cremation 3		cemetery	Disposition (Nem, crematory or ot	her pled					
Baltimore,	0 5 5 >		4 Donetion 5 Other (Spec		Voshe	ell Mem	ı. (	Gardens	07 - 14	-97 Dur	ndalk	, Md.
alt	permit. Pe Departmen Important: eny injury		21. Signeture of Funeral Service Lice	ensee		22. Name end	Addres	ss of Fecility E	Baltimo	ore, Ma	aryla	nd 21202
œ	20 5 5 8		Karen m.	1 Cocen		WM.C.	Mar	ch FH ]	101 E	. North	a Ave	niie
			23a. Part1. Enter the diseese, or con shock, or heart failure. List only	nplications that caused the	death. Do no						1	Approximate Intervel Between
0	Physician			1							Ċ	Onset end Deeth
1	/Medical Examiner		Immediate Ceuse (Final disease or condition	· Urina	m. 5	21200						
н	CXammer	L	resulting in deeth)	Due	to (dr es e co	onsequence of):						
-	pe ti	line		b								
	and and I-tran	Examiner	Sequentially list conditions,	Due	to (or es e co	nsequence of):						
.09	be ed ician buria		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	C								
68760,	certificete be executed nding physician and use es the bunial-transit	edical	thet initiated events resulting in death) Last	Due	to (or es e co	nsequence of):						
Box (	in ge	2		d								
ğ	es that the death ce igned by the attendi be detached for use	Completed by Physician/	Death Other stanishes at a state						l cot mid			
0	the cy the achex	hys	Part II. Other significent conditions		_	ne underlying ca	use giv	өп іп Реқ І.		Yes 2 No		the cause of death?
Д,	that the ned by the detach	y P	Gastromes	tomal DU	recl.				''	108 2 110	3 Probe	ably 4 minown
rds	The law requires ate has been sign page 2 should be	D D	D	final bl					24a. Was	en eutopsy		e eutopsy findings
8	w require been si should	lete	Kespirator	, talune	2				репо	rmed?	com	ilable prior to apletion of cause eeth?
Re	The law ate has page 2	ш	,	J					10	Vac 2001	_	_
Vital Records,	ificate or, pag	Be Co	25. Was case referred to medical					26. Place of Dee		/\		Yes 2 No
>	3 0	0.8	examiner? 1 ☐ Yes 2 No	Hospital: Inpatient	2 ER/Outr	patient 3 DO/	A Oth	or		denca 6 □Oth	ner (Specify)	)
Jou	(1)	le l	27. Menner of Death	28e. Dete of injury (Month, Dey Ye	28b. Ti	me of 28	Bc. Injury			how injury occur		
0		랿	1 Daturel 5 ☐ Pending 2 ☐ Accident investigation	on	5// [11]	ury   M		Yes 2□No				
Division	after de Dinecta d in by	Certification	3 ☐ Suicide 6 ☐ Could not determine	28e. Plece of Injury - building, etc. (S	At home, far	n, street, factory,	office		28f. Location ( City or To	Street and Numi	ber or Rurel	Route Number,
	tal or all all or led in											
	tosp 4 hou furner ely fil	edical	29e. Certifier 1 CertifyIng P	hysician: To the best of my miner: On the besis of exa	knowledge,	death occurred e	t the tin	ne, date end place,	end due to the	cause(s) and m	anner es sta	ited.
	To the Hospital or within 24 hours aft. To the Funeral Dir completely filled in	pek		end manner stated.								
	J. V. J.	-	29b. Signature and title of certifier	02/	>			e number		29d. Date signe	u (Month, D	O (C-
	7		July	ul two	mos		2 <i>g</i> ,	4003211		-كالالا	7 1	1797
	J			completed cause of death	(hom 23a) (T	ype, Print)		Ba	ltimor	e, Md.	2121	15
			31. Date filed (Month, Pay, Year)	32. Registrates	Signature	+ (3	146	-TI 400	E 2401	W. Be	lvede	ere_Ave
	Sta Registr		JUL 1 4	1997 32 Hogs July	a Davids	m-Randell	2					

The second secon 

NO	DRMAN HORTT	SI	R .	State	of Mary	land / Dep <i>Ce</i>	artment <i>rtificate</i>				lental H	ygiene Reg. No.	97	21219
	Physic /Medi	ian	Decedent's Name (First, Middle NORMAN	e, Last) FRANK	SHORT	T, Sr.					2. Date of I Month July	Day	9 7	3. Time of Death 1:13p
	Exami		4a. Facility Name (If not institution 6102 EDLYNNE	0.5				4	ь. Сіtу, То ВАЦТ		cation of De	ath 4c. Coul	nty of Death	
	Funeral Director		5. Social Security Number 216-44-2529	6. Sex 1 M 2 □ F		yrs. last birthday, Yrs.	If Under 1 Months	Year Days	If Under Hours	Min.	8. Date of E (Month, I July 1		9. Birthpla	ce (State or Foreig V) Land
NATURE OF THE PARTY OF THE PART	or hart show	Director	Usual Residence of Decedent   10a. State   10b. County   Maryland   N/.   10e. Street and Number		100	City, Town or L		ode				10g. Citizen o	10c	d. Inside City Limits 1 Yes 2 No
020	af. overems 23s	by Funeral	6102 Edlynne 1  11. Marital Status  1 Never Married 210 Marr 3 Widowed 4 Divorced	12. Wes De	s 2X No Give		Was Deceder If Yes, specify 1 ☐ Yes 2 ☑			gin? (Spe n, Puerto I	cify Yes or N Rican, etc.)		S.A. ace - American lack, White, et cify:	c.
Maryland 21215-0029	ed within 72 hours yplene. er than "naturel", t, the Medical Ex	Completed	15. Decedent (Specify only highest Elementary/Secondery (0-12) 12 years	college	d) (1-4or 5+)	(Give	dent's Usual ( kind of work DO NOT use JCK Dri	done d retired	during mosi I) <u>r</u>			E1	Business/Indu	stry
aryland	should be to and Mental Hy is marked offh surrettic even	To Be	17. Father's Name (First, Middle, Bruce  19a. Informant's Name/Relations!	Eliott		19b. Meili	ng Address (S	Street	An	na l	Mildre	ed Alto  ber, City or Tov	n	<sup>Code)</sup> 21236
imore,	Department of Health a Important: If flem 27 is any Injury or other tra gncs.		Judith Shortt  20a. Method of Disposition  1 Bunial 2 Toremetion  4 Donetion 5 Other (S)  21. Signature of Funeral Service	pecify)	m State	5 Dui b. Plece of Dispo cemetery, cre Freen Mou	nhaven psition (Name matory or othe int Cre 2. Neme end A itchell	Pland Place	ace tory ss of Facilit	Apt. 7. eld 1	1-C F Date -12-97 Home	Baltimor 20c. Locatio	e, Mary n-city or Tow more, M	yland n, State Maryland
	hysician /Medical Examiner	_	23a. Part1. Enter the disease or shock or heart failure. List Immediate Causa (Final disease or condition resulting in death)	complications that only one ceuse on	t caused the content of the content		er the mode of	of dyin	g, such as	cardiac o	r respiratory		1	Approximate Intervel Between Onset and Death
Box 68760,	geein cernicate be executed e ettending physician and of for use es the bunal-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last	c		to (or as a conse								
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ō	ral di	on: To B	examiner?  XYes 2 No  27. Menner of Death	28a. Dat	Inpatient e of Injury	2 ER/Outpatie		Othe Injury Work	er: 4□ Nu	ırsing Hor	ne XXAe	sidence 6 00		
5	of Attention offer deat Director: in by the	Certification:	1 Patural 5 Pendin investig 3 Suicide 6 Could relations	not be 28e. Plac		At home, farm, st	М	1 🗆 1	Yes 2⊡I			(Street and Nu fown, State)	mber or Rural I	Route Number,
	Funeral C	lical C		g Phyeiclan: To th Examiner: On the										

State Registrar

Dennis J. Chute, MD

30. Name end eddress of person inc completed ceuse of death (Item 23a) (Type, Print)

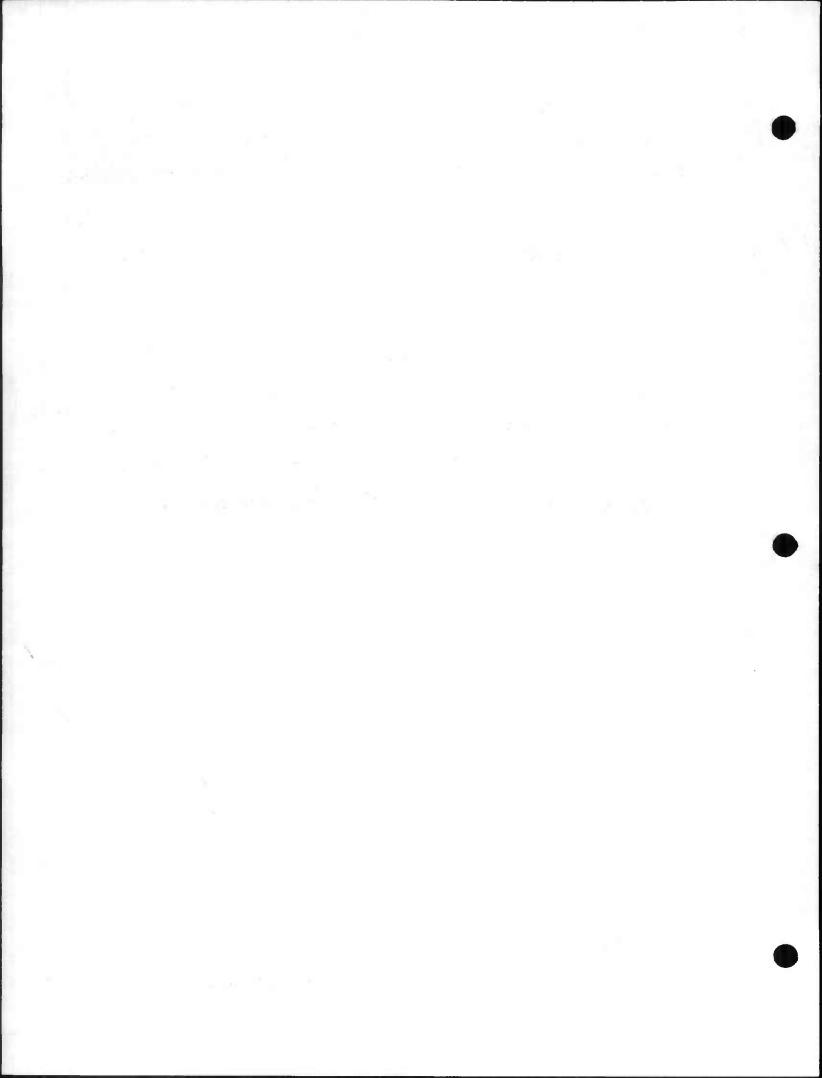
29b. Signeture and title of certifier

111 Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year) July 10, 1997



State of Maryland / Department of Health and Mental Hygiene

Item18 7-14-97 FilmG749 W.H.Per F/H Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** Month Simpkins 8:35 pm 214 /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Subacute Baltimore Baltimare City If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 15M 20 F 69 Days Yrs. 51-38-1140 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md 1 Nes 2 No NA Director MORE 28a-f 10e. Street end Number 10f. Zip Čode 10g. Citizen of Whet Country? ъ 902 21201 Items 23a AZU 252N 12. Wes Decedent Ever in U,S. Armed Porces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 ò 1 ☐ Yes 2 ☑ No Specify à 3 Widowed 4 □ Divorced 'natural', Completed the Medical 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiana. Elementery/Secondary (0-12) College (1-4or 5+) lerchant raman marked other 8. Mother's Name (First, Middle, Maiden Surneme)
Mattie 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 sent of Health and Mental 19b. Mailing Address (Street end Number of Rurel Route Number, City or Town, Stete, Zip Code) 21043 19e. Informant's Name/Relationship (Type, Print) Ħ Important: If Item 27 is any injury or other tra once. Davio 7805 YINES Ct. Ellicott City, Ild IMPKINS-JON 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Dete 1 □ Burial 2 □ Cremetion 3 □ Removal from State etro Crematoro 4 ☐ Donetion 5 ☐ Other (Specify) re of Funeral Service Licensee 22. Name end Address of Pacility West 23a. Penti. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart in ure. List only one cause on each line. 51512 Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical 2 days Examiner Due to (or es e consequence of) Preemania 2 mos The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of): P.O. Box 68760, Physician/Medicai Due to (or as e consequence of). Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deatb? 1 Yes 2 No 3 Probably 4 Obnknown Records, λq 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? , page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No After this certificate Division of Vital I or Attending Physician: 1 after death.
Director: After this certifica director. 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To filled in by the funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homleide To the Hospital of within 24 hours all To the Funeral Completely filled 1 G-Ertifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier Medicai 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print) reparation of Olumbia, mo State

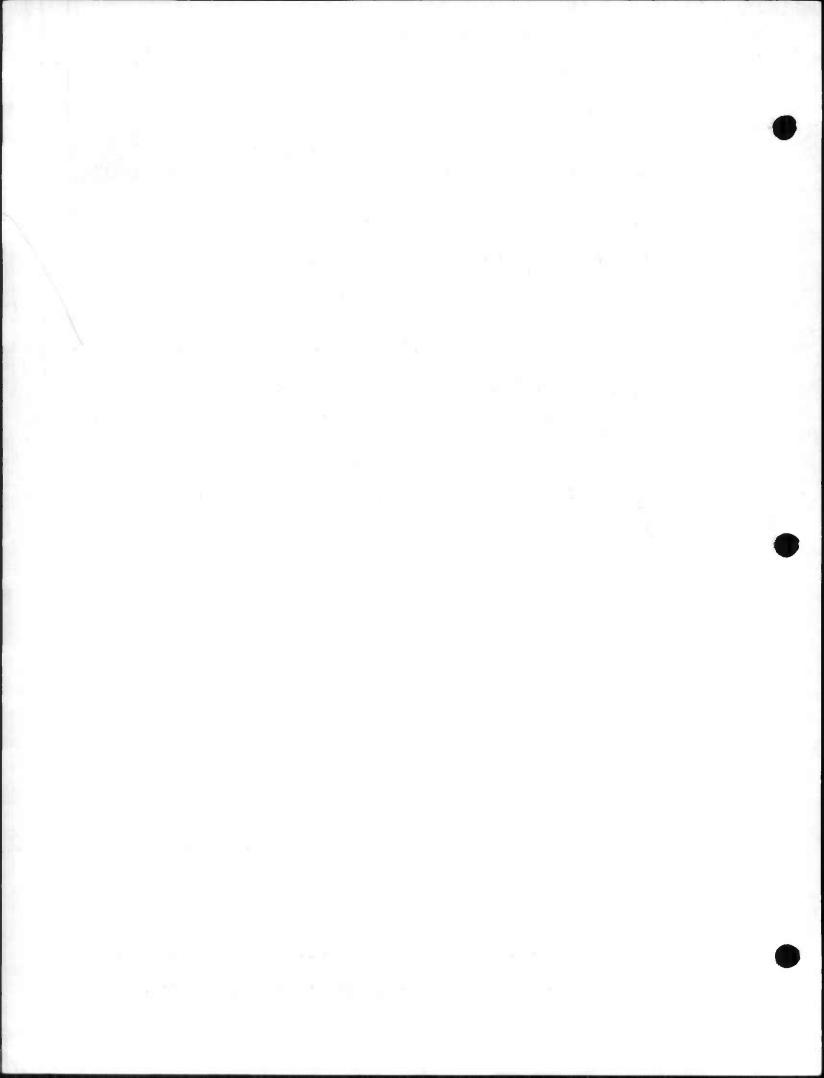
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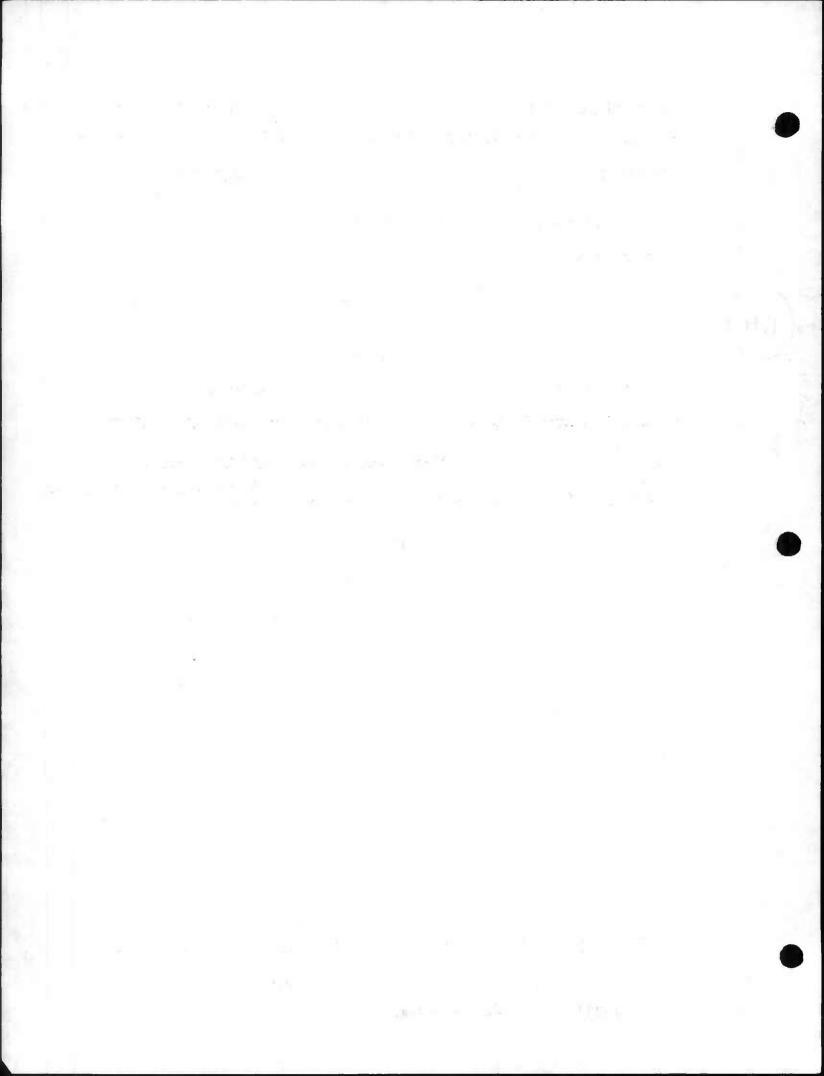
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Robert Stolte 1447 York RD. Lutherville, MA.			1/4	Nev	1100	D. 1.	/		1)	309/0		1/1	0/97	
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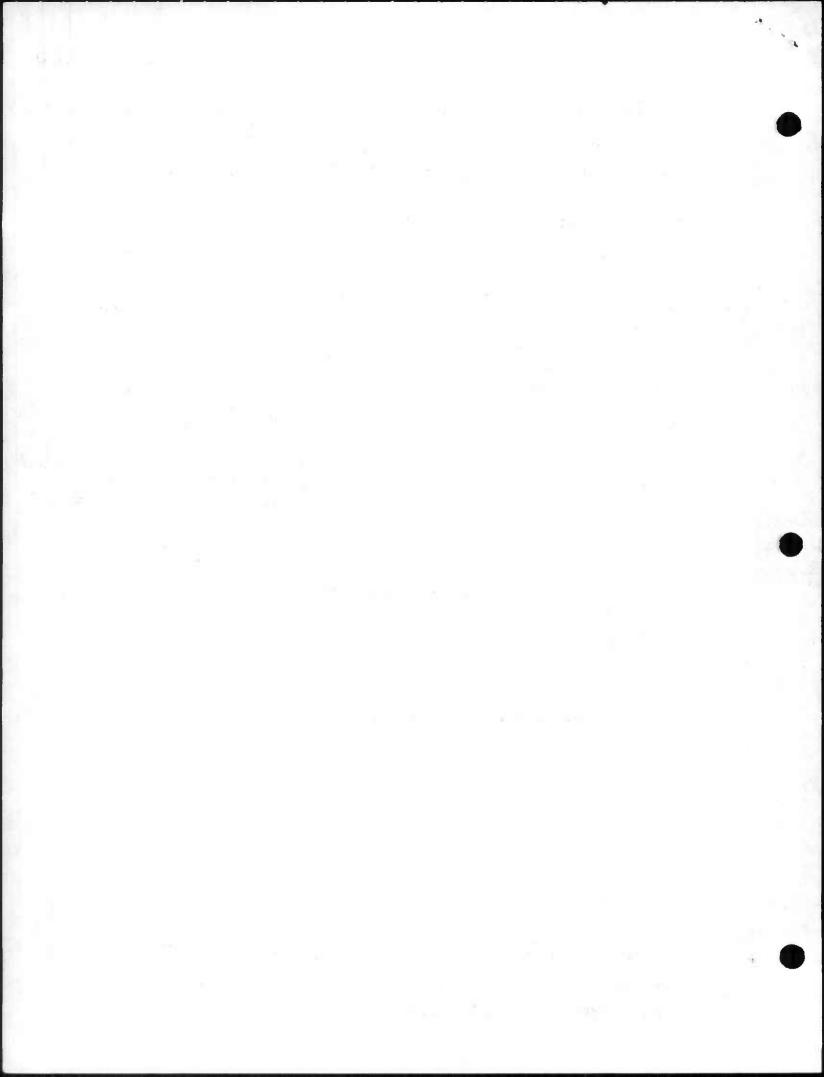


## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 2 1 2 2 4

						Certific	cate of	Death	F	Reg. No.			
	Dhualai		1. Decedent's Neme (First, Middle, La	ist)	6 . 0				2. Dete of Dee Month		Year		ime of Death
	Physici /Medi		BERNARD		208	OTKA			July	11 1	FPP	月	36 PM
	Examir		4e. Fecility Neme (If not institution, given	re street and number)				4b. City, Town, or L	ocation of Deeth	4c. Count	y of Deeth		
			The Good Samari					Baltimo		N/	Α		
	Funeral Director			Sex 7. Age	(In yrs. lest bir 65		Inder 1 Year oths Deys	Hours Min.	8. Date of Birth (Month, Day 09 /13/	, Yeer)	Coun	nace (State)	nd
	M M		10a. Stete 10b. County		10c. City, Tow	n or Location	)				1	0d. Insi	ide City Limits
	with the Maryland is or 28a-f show the notified at	Director	Maryland N/	Α	Bal	timore	f. Zip Code			10g. Citizen of	Minot Cours	/3	Yes 2□No
	death with ems 23a or it must be		2204 Louise Ave				2121			United	State	es	
0020	Eughber (Eughber	fby Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Exarmed Forces?  1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: (			specify Cub	dispenic Origin? (Sp an, Mexican, Puerto Specify:	Bican, etc.)	Special	ce - Americ ock, White, fy: Wh		an,
101	<b>科图</b>	ag ag	15. Decedent's E (Specify only highest gro	ducation ede com <i>pleted)</i>	16e.	Decedent's	Usual Occup	pation during most of work	kina	16b. Kind of E	Business/Inc	Justry	
2121	133	Æ	Elementary/Secondary (0-12)	College (1-4or 5+	)			during most of work d)	9				
7.00		S	12 17. Fether's Neme (First, Middle, Last	1		Lor	igshore		- /5	Port		ltin	nore
and	ed of	Be o	Vincent Sobo					18. Mother's Nam		Maiden Sumai	me)		
2	d Me mark matter	10	19e. Informant's Name/Relationship (		10h	Moiling Ad	dross /Stmot	Laura Tend Number or Rui	Dez	- C*T	04-4- 7/-	0-4-1	
Maryland	The Present of the Pr		Mrs. Patricia C.										01014
	Heal Hem 2 other		20e. Method of Disposition	SUDULKA / W	20b. Place of	Disposition	(Name of	Avenue	Baltimo	20c. Location			21214 nte
Baltimore,	Separtment of Separament of mportaint; If it in injury or other separaments or other separame		1 🕱 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia	y)	Morela	nd Mer	or other ple norial	Park	7/16/97	Baltin	nore,	Mar	yland
Bal	Departmer Departmer Important any Injury once.		21. Signeture of Funeral Service Lice	Mark T.	Zavoyna	a 22. Nan Le	onard	J. Ruck,	Inc.				
	3 31		23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plications that caused to one ceuse on each line	he death. Do r	not enter the	mode of dyir	ford Road	or respiretory err	more, N	daryla	Approx	21214 ximete al Between end Deeth
	hysician /Medical		Immediete Ceuse (Final	Cho	N. n. c		91	1001				17	Hours
E	Examiner		disease or condition resulting in death)	e. CAR				TUCK				1 7	10072
		ē		ACUTE	ue to (or es e			INFA	217104	3		171	LIDURE
	ansit	Examiner	Sequentially list conditions	D. —	ue to (or as e			. 1011	KCITOT	9		171	Hours
68760,	physician end sthe burial-transit	Medical Ex	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	ue to (or es e c								
Вох			•	d			<u>.                                    </u>						
Boy	es that the death ce igned by the attendi be detached for use	Physician/	Part II. Other eignificant conditions of	ontributing to death but	not resulting in	the underly	ina causa ak	van in Part I	23h Did to	phaces use co	ontribute to	the co	use of deeth?
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œ j	ite has	E O							1 □ Y	es 2 No	10	Yes	2□ No
ita	certificate	Be	25. Was case referred to medical examiner?					26. Plece of Deet	th (Check only or	ne)	1		
>	nis ce I dire	To I	1 Yes 2 No	Hospital: 1 🗷 Inpatient	2 □ ER/Ou	tpetient 3[	DOA Oth	ner: 4 - Nursing Ho	ome 5 Reside	ence 6 DOtt	her (Specify	1)	
ion o	within 24 hours after death, within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page		27. Manner of Deeth 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Dete of Injury (Month, Day		ime of njury M	28c. Injur Wor 1 🗆	ry et rk? Yes 2 □ No	28d. Describe h	ow injury occu	rred		
Divis	within 24 hours after deatl To the Funeral Director: completely filled in by the	Certification:	3 Sulcide 6 Could not b 4 Homicide determined		y - At home, fer (Specify)	rm, street, fa	ctory, office		28f. Location (Si City or Town	treet and Num n, State)	ber or Rura	l Route	Number,
Hook	24 hours Funeral	edicai C	29e. Certifier 15 Certifying Ph	yelclen: To the best of niner: On the basis of e	xeminetion end	, deeth occu	rred et the tir ation, in my o	me, dete and place, opinion, deeth occur	end due to the c red et the time, d	euse(s) and m ate end place,	anner as st	ated. the cer	use(s)
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	160.		30. Name end eddress of person who	completed ceuse of dee								, ,	
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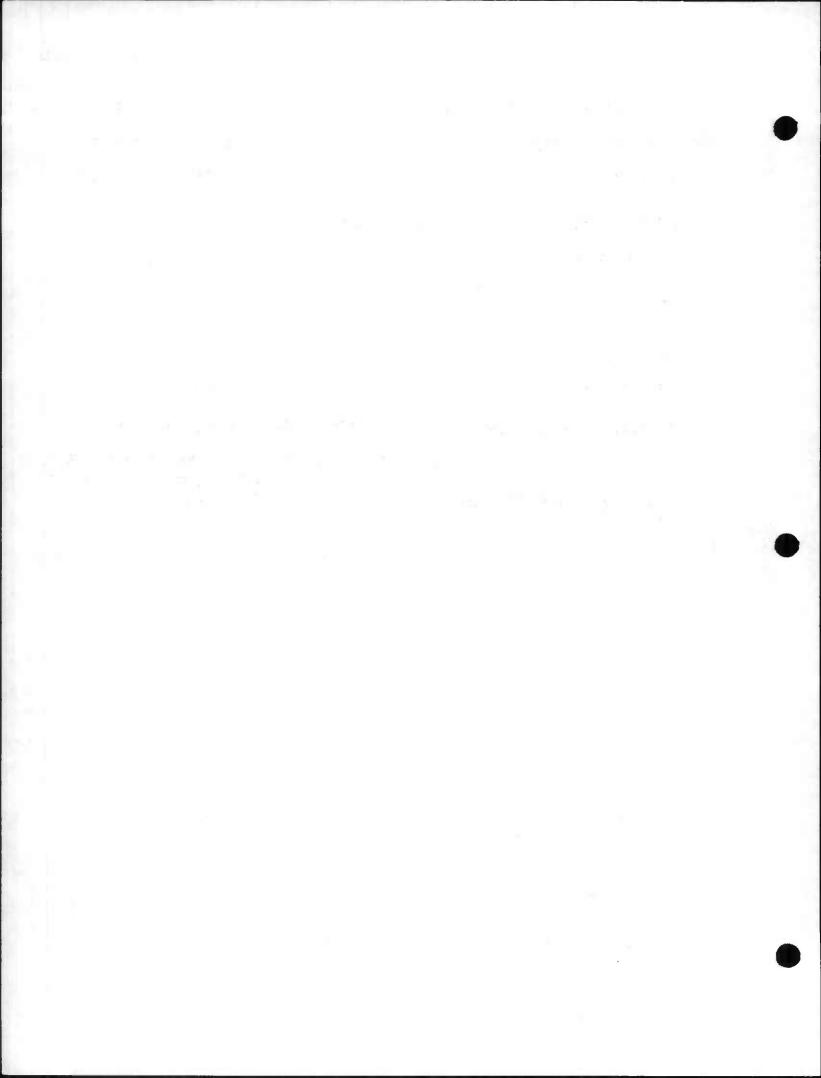
State of Maryland / Department of Health and Mental Hygiene 97

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	Physic /Medi		Theresa	D. Sch	olte				July	Pey	Year	9:30	D PM
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			3019 Third Ave					PARK		T	BAILIT	nort	
	Funeral Director		5. Social Security Number 6. Sa.  219 01 5929 10  Usual Residence of Decedent	7. Aga (In yrs	lest birthda 17 Yrs.	y) If Under Months	1 Year Days	If Undar 24 H Hours Mi	in. (Month, L	Dey, Yeer)	9. Birthpl Count	ace (State or F.	oreign
	yland M M		10a. Stete 10b. County	10c. C	ty, Town or	Location					10	d. Inside City I	Limits
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	ath with the 123e or 2 suit be n	neral Dire	3019 Third Ave			10f. Zip		1234		10g. Citizen of	What Count	ry?	
Maryland 21215-0020	高	by Fune	11. Merital Status  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. Wes Dacedant Ever in the Armed Forcas? 1 ☐ Yes 2 PNo If Yes, Give Yaar or Dates:	I,S. 13	If Yas, special 1 ☐ Yes	cify Cub	dispanic Origin? en, Mexicen, Pu Spacity:	(Specify Yas or Nerto Rican, etc.)		ce - America ck, White, e		
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Baltimore	mit. Pages partment of portant: If it injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donetion 5 ☐ Other (Specify)		cametery, cr	Redeen	ther ple	Cemitery	July 12	Balti		Maryl	land
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68760,	eeth certificete be executed attending physician and attending physician and Ifor use as the buriel-transit	edical Examiner	Immediate Cause (Finel disease or condition resulting in deeth)  Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Causa (Disease or injury that initiated avants resulting in deeth) Lest		consequence of the consequence o	equence of):	ext	aryas	Tery de	hear			
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L C	Ilng F I. After funer	0	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28e. Dete of Injury (Month, Dey Year)	28b. Time injury		Bc. Injur Wor		28d. Describe	how injury occur	red		
Division	al or Attending Physician: The is a filer death. Is Director: After this certificate he of in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicida 6 Could not be 4 Homicide determined	28e. Plece of Injury - At h- building, etc. (Specif	ome, farm, s	treet, fectory,		Yes 2□No	28f. Location City or To	(Street end Numb own, Stete)	er or Rural	Route Number,	r,
	To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	edical (	29a. Certifier (Check only one)	Icien: To the best of my kno er: On the bests of exemina and menner stetad.	wledge, dee tion end/or l	th occurred envestigation,	et the tin	ne, dete end plea pinion, deeth occ	ce, end due to the curred et the time	ceuse(s) end me , dete end piece,	enner es ste	ted. he cause(s)	
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	5		30. Neme end address of person who cor	mpleted ceuse of deeth (Iten		,		12102					
				lewski MJ		8404	+	tarford	Rd.	Baltimor	e MI	ι.	
Ü	Sta	te	31. Dete filed (Month, Dey, Year)	22. Resistrer's Signa		4		1-70		J		-1	



State of Maryland / Department of Health and Mental Hygiene 97

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	La Tar		1. Decedant's Nama (First, Middla, Las	st)		-		_	- 1	2. Data of Deat	th	Maria	3. Tima	of Death
ш	Physici /Medic		GLADYS	MAY	TRAPP					Month JUL.	9 Day	997	9:	30 am
	Examir		4a. Facility Nama (If not institution, give					4b. City, To		ation of Daath	4c. County			
	Funeral		1010 HILLPINE RO	ax 7. Age	a (In yrs. last b		nder 1 Yea			ER B. Data of Birth (Month, Day,		LTIMO		a o <i>r Foreign</i>
	Director		219-10-6119 Usual Rasidance of Decedant	□M 2ÅF	80	Yrs. Mon	ths Day	s Hours	Min.	JUL 18	1916	MARY	LAND	
	within 72 hours after death with the Maryland ena. than "natural", or items 23a or 28e-f show the Mexical Examiner must be realthed at	Director	10a. Stata 10b. County  MARYLAND BALTIMO	ORE	10c. City, Tov	DDLE R							1 □ Ya	City Limits
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Maryland 21215-0020	J within 72 hours after death with the Maryla Jena. r than "natural", or items 23a or 28a-1 show the Moxical Examiner must be multiped at	by Funeral	11. Marital Status  1 Navar Marriad 2 Married  3 Widowad 4 Divorced	12. Was Decedent I Armed Forcas? 1 ☐ Yas 2 ☑ N If Yas, Giva Yaar or Datas:			specify Cu		gin? (Spec i, Puarto Ri	ify Yes or No- ican, atc.)		e - Americ ck, White,	etc.	
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Baltimore,	permit. Pages 1 and Department of Health Important: if item 27 any injury or other tr once.		XXBurlal 2 Crametion 3 🗆		cemate	iry, cramatory	or othar p		7					DVI AND
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	Physician /Medical Examiner		Immadiata Causa (Final disaasa or condition rasulting in death)	a. M.	-taste	esic	Colu	n Ca	Ycin	ma		de de de	Onset an	mths
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Ä	The la	E O								1 □ Ya	as 2 No	10	∃Yes 2	□ No
ita	iclan: The	Be	25. Was casa referred to medical examinar?					26. Placa	of Daath	Check only on	a)			
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n	D je e	:: 0	27. Mannar of Death 1 ☐ Hatural 5 ☐ Pending	28a. Data of Injur (Month, Day		Tima of Injury	28c. inj	jury at lork?	28	d. Dascribe ho	ow injury occur	red		
sio	Attanding ir death. ector: After by the fune	cati	2 Accidant invastigation 3 Suicida 6 Could not be			M		☐Yas 2☐I						
Division	tal or Attandir rs aftar death. al Director: Af led in by the fu	Certification:	4 Homicide datarmined	28a. Place of Inju building, ato	iry - At home, f :. <i>(Spacify)</i>	arm, street, fac	otory, office	a	28	If. Location (St City or Town	traat and Numi n, State)	ba <i>r</i> or Rura	I/Routa N	umber,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edicai	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Msdlcal Exsm	ysicisn: To the best of liner: On tha basis of and mannar sta	axamination ar	a, daath occur nd/or investiga	red at tha tion, In my	time, date and opinion, dae	d place, an th occurred	d due to the ca d at tha tima, d	ause(s) and ma ata and place,	anner as si and due to	tated. the caus	a(s)
	To the within 2 To the complete	M	29b. Signature and titla of certifiar				29c. Lica	nsa number	7	2	9d. Data signe	d (Month,	Day, Year	)
	17		1/3 mD				D	1848	/		7/11/	97		
	A		30. Nama and address of person who of MYO THANT	completed cause of de	aath (Itam 23a) HOSPITI	(Typa, Print)	IVE	, B	DLTIM	notes	mo.	2123	37	•
	Sta	te	31. Date filed (Month, Day, Year)	Registra										



97-3798-510 AMARTHUR TURNER

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Departn

Certificate of Death Reg. No.

2. Dete of Deeth

Month

nent of Health and Mental Hygiene	97	2	12	22	5.	7
coto of Dooth						

**Physician** /Medical **Examiner** 

**Funeral** 

Director

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**Physician** /Medical

Examiner

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Certification: To

Medical

三海 Important: It any injury o once. Department

the Medical

Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Heelth end Mental Hygiena.

Baltimore, Maryland 21215-0020

Arthur E. Turner 4a. Fecility Neme (If not institution, give street and number) 2121 WINDSORGARDEN LA.

10b. County

1. Decedent's Name (First, Middle, Last)

JULY 4b. City, Town, or Location of Death

Year 10,1997 7:32 P 4c. County of Deeth

3. Time of Deeth

5. Sociel Security Number

APT.C432 7. Age (In yrs. last birthday) 10M 2□ F 65

BALTIMORE If Under 1 Year If Under 24 Hrs.
Hours Min.

N/A Birthplace (State or Foreign Country)

Md

212-28-0636 Usuel Residence of Decedent

10a State

Md.

Director

Funeral

þ

Completed

Be

N/A

10c. City, Town or Location Baltimore

Yrs.

10d. Inside City Limits 1 Ves 2 No

10e. Street end Number

10f. Zip Code 21207

Deys

10g. Citizen of What Country? U.S.A.

2121 Windsor Garden Lane Apt. 432

11. Marital Status 1 □ Never Married 2 □ Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) NG Yes 2 □ No 12/1952 If Yes, Give

10/1954

1 ☐ Yes 2 ☑ XNo Specify: 14. Race - American Indien, Bleck, White, etc. Specify: Black

Elementary/Secondary (0-12)

15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry American Smelting & Refinning Co.

Grade

17. Fether's Name (First, Middle, Last)

Pipe Fitter

18. Mother's Name (First, Middle, Meiden Sumeme)

Feb. 25, 1932

John Turner

19a. Informent's Name/Relationship (Type, Print) daughter

Fannie Pye

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)

Yvette Jackson-Bey

20b. Place of Disposition (Neme of cemetery, cremetory or other place)

408 Village Of Pine Ct. Apt 3B Balto., Md. 21244 Dete 20c. Location - City or Town, Stete

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donetion 5 Other (Specify)

Garrison Forest Veterans July 15 Owings Mills, Md.

21. Signature of F oral Se rvice Licensee

22. Name and Address of Fecility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. sease, or compilections that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, ilure. List only one ceuse on each line.

Approximete Intervel Between Onset end Death

Immediate Ce use (Final disease or condition resulting In death)

. Arteriosclerotic Cardiovascular Disease

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest

25. Wes case referred to medical

1 Netural 2 Accident

29a. Certifier

Due to (or es e consequence of):

Due to (or es e consequença of)

Pert II. Other eignificent conditione contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobecco uee contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en eutopsy performed?

24b. Were eutopsy findings evelleble prior to completion of cause of deeth?

1 ☐ Yes 2 No

INSPECTION 1 ☐ Yes 2 ☑ No

> 26. Piece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 💆 Residence 6 ☐ Other (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No 27. Menner of Deeth

5 Pending

Investigation

28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury

28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Location (Street end Number or Rural Route Number, City or Town, Stete)

29b. Signature nd title of certifie

1 Certifying Phyelcien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted. 2M Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number 29d. Dete signed (Month, Day, Year)

OCME

JULY 11,1997

of death (Item 23e) (Type, Print)

Locke M.D. Laron

111 Penn Street, Baltimore, Maryland 21201 2. Pegistrar's Signature

Hospital or Attending Physician: The law requires that the death certificata be axecuted P.O. Box 68760. Records, Division of Vital s after death.

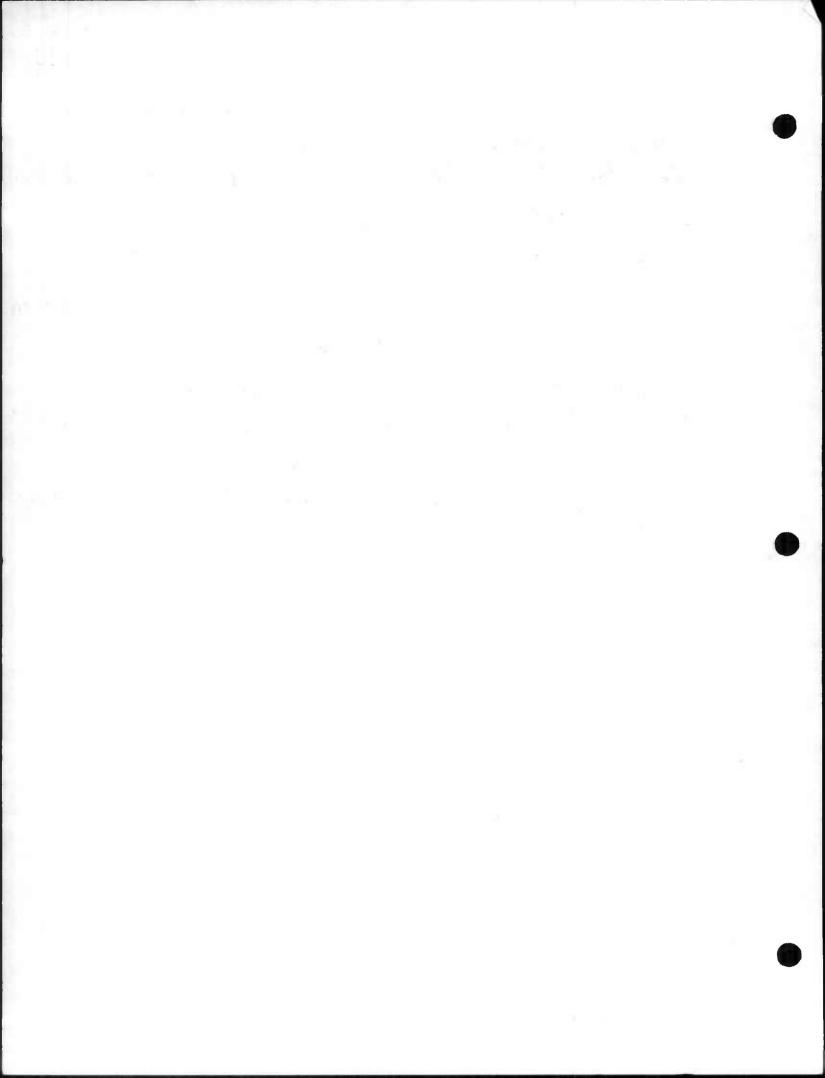
State Registrar

To the Hospital within 24 hours a To the Funeral C

State of Maryland / Department of Health and Mental Hygiene Q 7 21220

						ate of Death		Reg. No.	1 41	220
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Dey	Year 3. T	ime of Death
	/Media		Isaac	lobn	_		-	11,1997		5:04 p
À	Examir	ner	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	4c. County	of Dylath	
_			THE JOHNS HOPKINS  5. Social Security Number 6. September		fact hinthdays H Line	BALTIMO	RE CITY		1//	
	Funeral Director		246-20-6169 1) Usual Residence of Decedent	M 2□F 7.6	Yrs. Month		8. Date of Bir (Month, Da	3,1925	Country)	Carolina
	ylend		10a. Sfete 10b. County	10c. Ci	ty, Town or Location				10d. ins	side City Limits
	e Ma	Funeral Director	Maryland N/	4	Baltin	nore			1,6	Yes 2□No
	in th	Dire	10e. Street end Number	101	10f. 2	Zip Code		10g. Citizen of V	Vhat Country?	
	23a	rai	2520 Harto	ord Kd.		21218		- 1	15H	
	tems tems	une		12. Wes Decedent Ever in the Armed Forces? 1 ☐ Yes 2 No	I,S. 13. Was Dec	edent of Hispanic Origin? (S becify Cuben, Mexican, Puert	pecify Yes or No o Rican, efc.)	14. Raci Biad	a - American Ind k, Whife, efc.	ian,
0200-61212	ages 1 and 2 should be filed within 72 hours aftar death with the Maryland 11 of Health and Mantal Hygiene. If it em 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic svent, the Medical Examinar must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorcad	1 ☐ Yes 2 € No If Yes, Give Year or Dates:	1 □ Yes	2 No Specify:		Pocity	ican f	Americar
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	filed Hygid Sther ent,		17. Father's Name (First, Middle, Last)	O	Luci	18. Mother's Nar	ne (First, Middle,	Maiden Surnam	e) 911 (	11435 CO
Maryland	Mantai Mantai arked o	To Be	John Tor	n		124	10. 1	011)10		
aZ	and Man is marke	-	19a. Informant's Name/Reletionship (Ty	De, Print) I (niece	19b. Mailing Addre	ess (Street and Number or Ru	ıral Route Numbe	or, City or Town.	Stete, Zip Code,	)
	1 and 2 Health a em 27 Is		Mrs. Theatus	5 Houston	5421	Jonguil ,	Ave.	Balto	o. Md.	2/2/5
e e	of He of He litem		20a. Method of Disposition		Place of Disposition (A	lame of rother place)	/ Defe/	20c. Location -	City or Town, St	ate
Ĕ	Peges nent of I int: If ite iry or o'		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	Druid	Ridge	1/19/97	Kalta	1. Ma	1.
baitimore,	permit. Peges 1 and Department of Health Important: If item 27 any injury or other ti		21. Signature of Funeral Service Ucense	000	22. Name	and Address of Facility			11.	
11	Dep per per per per per per per per per p		▶ Carent	L. Kus	1 3050	Ph Li Nor	A run	eraj	Tomm	1 21216
	76		23a. Part 1/ Enfer the disease, or compliantick for heart failure. List only or	cations thef caused the dear	h. Do not enter the m	ode of dying, such es cardiac	or respirefory e	rest,	Appre	oximete val Between
	Physician		U U						Onse	t and Death
	/Medical Examiner		Immediate Cause (Final disease or condition	Sepsis					3de	145
	- Zuminor	_	resulting in death)	l l	or as a consequence o	f):			I	
	ted nsit	Examiner	_ b	liver failure					24ea	13
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<b>68/6</b> 0,	ificate be axecuted g physician and as the burial-transit	edicai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Duo to (e		ρ,			1	
Q	E 0166	edi	resulting in death) Last	0) 0) 0) 000	r as a consequença o	1).				
ŏ	The law requires that tha death cartifics ite has been signed by the attending phage 2 should be detached for use as t	an/N	d							
Vital Records, P.O. Box	deat le atte	Physician/N	Part II. Other significant conditions con	tributing to death but not res	ulting in the underlying	g cause given in Part I.	23b. Did 1	obacco uae cor	ntribute to the c	auee of death?
	at tha	Phy			, ,		10	res 2□ No	3 Probably	4 Unknown
ທົ	es the	by								
0	v requires thet tha de been signed by the s should be detached	Completed					24a. Was	an autopsy med?	24b. Were eut available	prior fo
Ö	as be	ple							of death?	on of cause
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7 1 2	clan: artific ector,	Be	25. Was case referred to medical examiner?				ath (Check only o	ne)		
5	hysi this o	우	I Tes ZISKNO		ER/Outpatienf 3□ I		lome 5 Resid			
	ing F	ion	27. Menner of Death  1 Netural 5 □ Pending	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe	ow injury occurr	ed	
20	death death stor:	Icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	290 Place of Injury At h	M street feet	1 Yes 2 No	29f Location /	Street and Numb	er or Rurel Rout	a Number
DIVISION OF	or A efter Direct	Certification:	4 ☐ Homicide determined	28e. Placa of Injury - At h building, etc. (Specia	y)	ory, onice	City or Tov	m, State)	er or Hurer Hour	e rvuitiber,
_	To the Hospital or Attending Physician: within 24 hours after deals are after deals To the Funeral Director: After this cardifice completely filled in by the funeral director,		29a. Certifier TSCertifyIng Phya	Iclan: To the best of my kno	wledge, death occurre	d af the time, date and placa	, and due to the	ause(s) and ma	nner as stated	
	n 24 h	edical	(Check only 2 Medical Examin	er: On the basis of examina end manner stated.	tion and/or investigation	on, in my opinion, death occu	rred at the time,	date and placa,	end due to the ca	ause(s)
	To the comp	M	29b. Signature and fitle of cartifier		2	9c. License number		29d. Date signed	d (Month, Dey, Y	'ear)
^	,[		Telly Alo, Senio	Resident		RES-000		July 14,	1997	
	1		30. Name and address of person who co					1 11		
1	$\langle \langle \langle \rangle \rangle$		Kelly Geno 601 N	borth Wolfe St, B		71987				
	Sta	te	31. Dete filed (Month, Dey, Year)	2. Registrar's Signa	ture					

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death **Physician** Bartalnia JULY 10 1997 /Medical 2:15 am 4b. City, Town, or Location of Death 4c. County of Death 4e. Facility Neme (If not institution, give street end number) **Examiner** 8. Date of Birth (Month, Day, Year) THE JOHNS HOPKINS HOSPITAL BALTIMORE
If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 19M 20 F Months Days Hours Min. 52 Yrs. Va. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore 1 Tes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? AUR 1920 Cecil 21218 U.S.A Funeral 11. Marital Status 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify onfy highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) -acilities COOK NA 6th ande 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be yancı, TAylor SR. sar thonia Nelson bar. 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21212 WILSON Gilrubin Apt 11 Batto. , ms Subble Jean 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Locetion - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Battimore, MD Greenmount 7-12-97 aEM. 4 ☐ Donation 5 ☐ Other (Specify) al Funeral Service Lices 22. Name and Address of Facility North tue 1101 EAST F. H. March he the disease of complications had cause heart failure. List only one cause on each Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset end Death Immediate Cause (Final Sepsis 48 horurs disease or condition resulting in death) Due to (or as a consequence of): iver failure 5 years Exami Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings aveileble prior to Completed 24a. Wes an autopsy completion of ceuse of deeth? 25 No 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25€No 10 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and menner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Yeer) 29c. License number Dow no July 10, 1997 RES.CO

Baltimore, Md.

JOHNS HOPKINS HOSPITAL 600 N. Wolfe Street 21287

State Registrar

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be nothed at

permit. Pages 1 end 2 should be filed wi Department of Health end Mentel Hygien. Important: if them 27 is marked other that any injury or other treumstic event

Physician /Medical

Examiner

burial-trensit

ettending physician for use es the buris

signed by the

cate hes been sig

certificate

rector After

To the Funerard To the Funerard

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Box 68760.

P.O. I

Records.

Division of Vital Attending Physician:

The law requires that the death certificete be

the Meryland

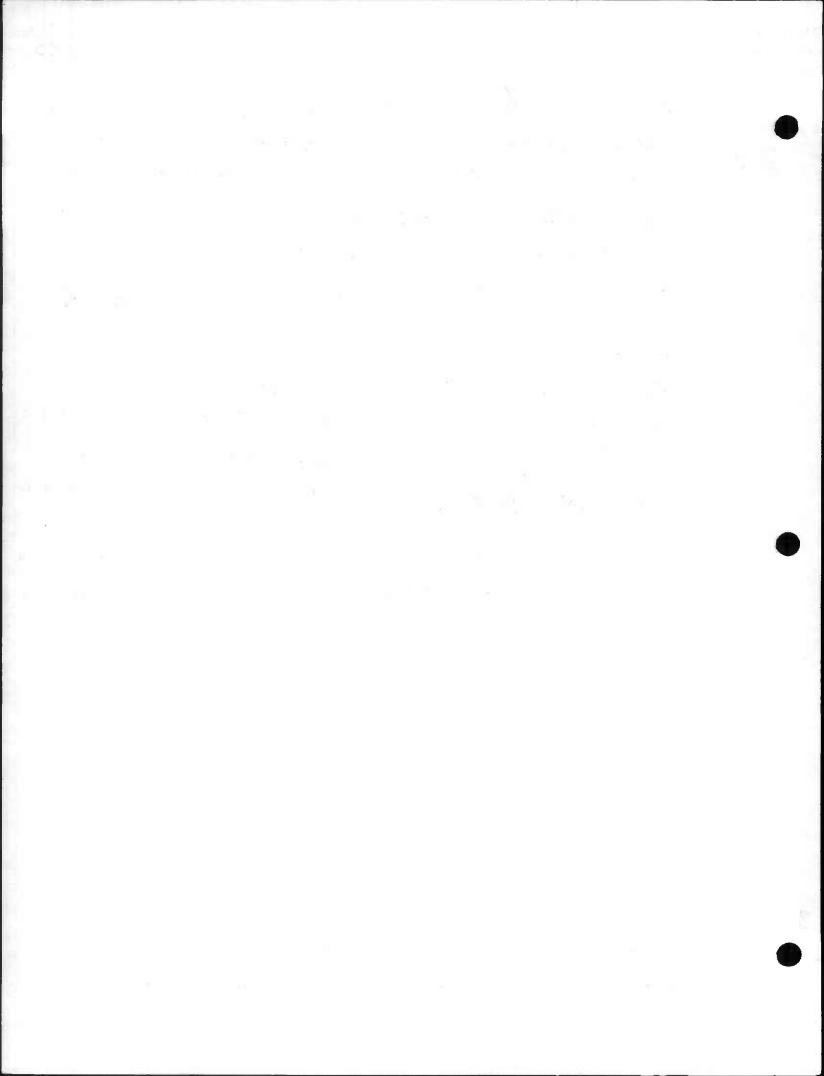
Baltimore, Maryland 21215-0020

31. Date filed (Month, Day, Year)

BREWSTER

32. Registrar's Signature who Davidson

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

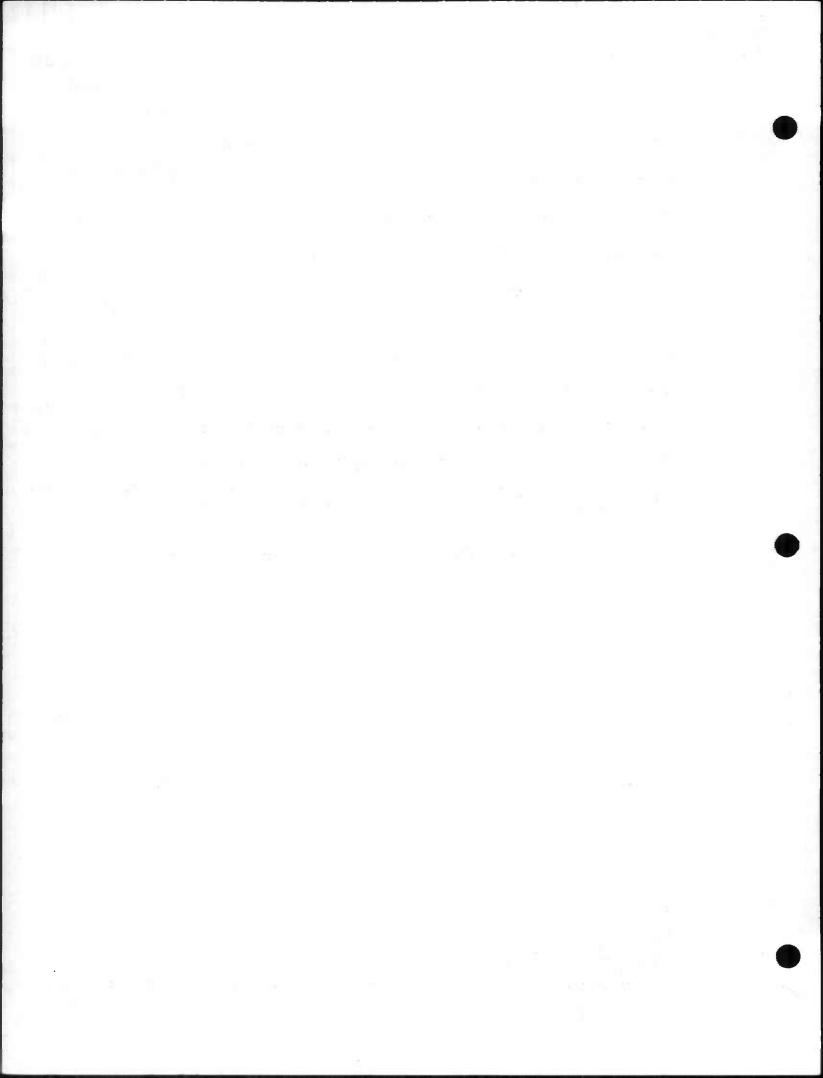


	State o	of Maryland	/ Department of Health and Mental Hygiene	97	2	10	21	
Film G749	7-15-97	ria	Cortificate of Dooth	21	-	1 6	- 01	

		It	em 5 per FH Film G749  1. Decadant's Nama (First, Middla, Las			ertificate			2. Data of D	Reg. No.	- Sina I	ima of Death
П	Physic	an		•	mas				Month	Day	Year	
u	/Medi		4a. Fecility Nama (If not institution, give		and b		4h	. City, Town, or Lo	JULY			:25 PM
1	Exami	ıer	1345 GORSUCH									
	Funeral Director		5. Sociel Security Number 6. Se	7. Aga (la	n yrs. last birthda 3 Yrs.	Months   D	Yaar Days	BALTIN If Under 24 Hrs. Hours Min.	8. Data of Bi (Month, D	NA rth ay, Year) 23-34	9. Birthplaca (: Country)	Stata or Foraign
	yland		10a. Stata 10b. County		c. City, Town or	Location					10d. In:	sida City Limits
	Mar a-fsl	tor	Md N	A	Balt	imore					18	Yas 2 No
	or 28	Oire	10e. Street end Number			10f. Zip Co				10g. Citizen of	What Country?	
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020	72 hours after death with the Maryland naturel, or Items 23a or 28a-f show deal Examiner over be notitied at	by Funeral Director	11. Maritel Status  1 Navar Married 2 Marriad  3 Widowad 4 Divorced	12. Was Decedant Eva Armed Forcas? 1 ☑ Yas 2 ☐ No If Yas, Giva Yaar or Datas:	r in U,S.	3. Wes Dacedan If Yes, specify		panic Origin? (Sp , Maxican, Puarto Specify:	ecify Yes or N Rican, atc.)	5 14. Rad Bla Specif	ce - Amarican Ind ck, Whita, atc. by: Blac!	
Baltimore, Maryland 21215-0020	c * 4	Completed	15. Dacedent's Edi (Specify only highest great	da completed)	16a. De (Gi life	cedent's Usual C va kind of work of DO NOT usa r	occupat dona du ratired)	ion uring most of work	ing	16b. Kind of B	usinass/Industry	
212	d within giene. r than "	E O	Elementery/Secondary (0-12)	College (1-4or 5+)  lyear		rter				Levin	gton Ma	arket
b	be filed tal Hygid d other event,	Be	17. Fether's Name (First, Middle, Last)					18. Mothar's Nam	a (First, Middle			11-10-0
yla		Tol	Theodore R.	Thomas				France		Bowma		
Jar			19a. Informant's Name/Ralationship (T	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				nd Number or Rur				
e,	1 and 2 Health em 27 I		Patricia Bowle 20a. Mathod of Disposition		134	5 Gorsi	uch	Avenue		imore,	Maryla	and
Jor	ages nt of h		1 ☐ Burial 2 ☐ Cramation 3 ☐ I	damovai from Stata	20b. Place of Dis cametary, c			1	Data		- City or Town, Si	
틆	permit. Pages 1 and 2 Department of Health of Important: If Item 27 is any Injury or othar tra once.		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Ligan)		Green	mount ( 22. Name and A		etery (				
Ba	Depa Impo any It		A so A so A			ZZ. Name and A	voorass	Ba	altimo	re, Ma	ryland	21202
£	_	H	23a Part 1 Enter the disease or comp	lications that caused the	death Do not	WM.C. I	Mar	ch FH ]	101 E	. Nort		1e oximata
	Physician		23a. Part1. Entar the disaasa, or comp shock, or heart feilura. List only o	ne ceuse on aach lina.	daan. Donote	intal tha moda o	n dynig.	, such as cardiac	or raspiratory i	arrast,	intan	val Batween
	/Medical	Н	Immadiata Causa (Final	Arterio	sclero	tic Car	rdi	ดงลระเป	ar Di	92892		
	Examiner		disaasa or condition resulting in daath)	a	e to (or es e cons			0145043	LUI DI	beabe	1	
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-	cate be executed physician and s the burist-transit	Examiner	Sequantially list conditions,	Due	a to (or as a cons	saquance of):						
60,	burls burls		Sequantially list conditions, it any, leeding to immadiate cause. Enter Underlying Cause (Diseasa or injury	c								
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Vital Records,	v requires been sign should be								24a. Was	s an autopsy ormad?	24b. Ware au availabla	prior to
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	To the within 2 To the comple	Me	290 Signature and title of certifier	.0		29c. Li		number		-	ad (Month, Day, )	
)	1		Marke	NU)			0	.C.M.E.		JULY 13	3, 1997	
	5		34 Name end eddrass of person who co									
			J. Laron Locke	e M.D.	111 I	enn St	re	et, Bal	timor	e, Mary	yland 2	1201

State Registrar

31. Data filad (Month, Day, Yaar) JUL 1 4 1997

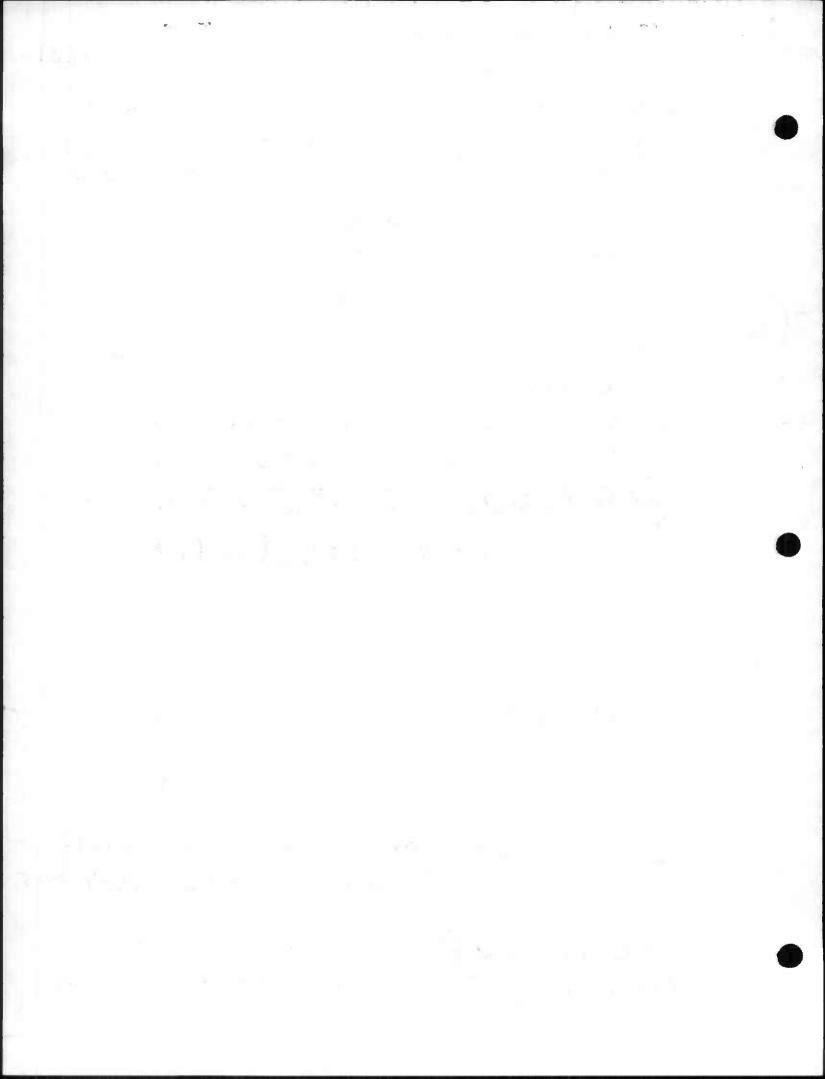


WRC

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Physic /Med Exam Funera Directo	lical	Decedent's Neme (First, Middle, L     Marshal Vincent \     4a. Fecility Neme (If not institution, ga	endetti					2. Date of Deet Month JULY	Dey	Year 997	3. Time 5:1	of Deeth	
/Med Exam Funera Directo	lical										5 - 1		
Exam Funera Directo		4a. Fecility Neme (If not institution, ga	is street and sumber									.0 PM	
Directo			ve street end number)				4b. City, Town, or L	ocation of Death	4c. County				
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773		220-72-4736		9e <i>(In yrs. le</i> 38	est birthday) Yrs.	Months Days	r If Under 24 Hrs. Hours Min.	If Under 24 Hrs. North, Dey, Year) Hours Min. Feb 24, 1959  8. Date of Birth (Month, Dey, Year) Feb 24, 1959  9. Birthplece (Stat Country) Maryland				a or Foreign	
pue Ma		Usual Residenca of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				10	Od Inside	City Limits	
th with the Merylen 23a or 28a-f show	0	Maryland						1 ☐ Yes 2 ☐ No					
the 28a	Directo	10e. Street end Number				10f. Zip Code			10g. Citizen of Whet Country?				
3a or		5028 E. Eager St.				21205		U.S.A.			,.		
out the death with the Meryland	Funeral	11. Marital Status		as Decedent Ever in U,S. 13. Wes Decedent		Wes Decedent of	of Hispenic Origin? (Specify Yes or No						
		Armed Forces?  1 ★ Never Married 2		If Yes, specify Cu			ben, Mexican, Puerto Rican, etc.)  Specify:		Black, White, etc.  Specify: White				
图数	Completed by	15. Decedent's E				lent's Usuel Occu	upetion		16b. Kind of Business/Industry				
	pie	(Specify only highest gi	College (1-4or 5+)				e during most of working red)						
	Con	12				Entertainer			Show Business				
htal H M off	Be	17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Malden Surneme)						
should be nd Mental marked o	2						Diana						
CA 60 80 60		19a. Informent's Neme/Reletionship					t end Number or Rui						
leal leal		William J. Vendet 20a. Method of Disposition	ci (Father	-		AMYCLAE sition (Neme of	Place Be	-					
S 0		1 ☐ Burlal 2 ☑ Cremetion 3 [		СӨ	metery, cren	netory or other ple			20c. Location -				
ermit. Pages 1 er Department of Hea mportant: If item iny injury or other		4 Donetion 5 Other (Specify) Greenmount Crematory 7/15/1997 Baltimore Md.											
permit. Page Department of Important: If is any injury or once.		21. Signature of Funeral Service Licensee  22. Name and Address of Fecility  Bruzdzinski Funeral Home P.A.  1407 Old Eastern Avenue Essex, Md. 21221  23a Fartt Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, Indeed, or heert feilure. List only one cause on each line.  Approximate Intervel Between											
Physician /Medical	_		$\bigcap$	1	A	1 4	1. 1	100	4	i	Onset en	d Death	
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Hosp 24 hor Fune stely fi	edicai	29a. Certifier (Checken) Control on the besis of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Checken) Checken on the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										e(s)	
0 - 0 -	ĕ E	29b. Signature end title of certifier 29c. License number					se number	29d. Date signed (Month, Dey, Year)			)		
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To the Hospital or Attanding Ph within 24 hours effer death. To the Funeral Director: Affer th completely filled in by the funeral		Maril	v lod	W)		0	.C.M.E.	J	ULY :	11,	1997		

State Registrar



State of Maryland / Department of Health and Mental Hygiene 9 /

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Edwin VESTAL July 13, 1997 11:07 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Center Rosedale If Under 24 Hrs. Baltimore 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1₽M 2□ F Months Days Hours 216-20-3437 71 Yrs. Director Jan. 3, 1926 North Carolina Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore ESSEX 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 ns 23a 2027 Middleborough Rd. 21221 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 52 Yes 2 □ No If Yes, Give Year or Dates: WW I 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced WW II Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 21 Manager Food Store Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental marked William C. Vestal Carrie G. Lang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health a f Nem 27 l Beulah Vestal (Wife) 2027 Middleborough Rd. Baltimore, Md. 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) m 8 Holly Hill Mem. Gardens 7/15/1997 Baltimore Co.Md Funeral Service Licenses 22. Name and Address of Fecility Department in Bruzdzinski Funeral Home P.A. D.Wikouske 1407 Old Eastern Avenue Essex, Md. 21221 234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thick, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final Respiratory Failure 10 years disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease/Emphysema pue Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician e Box 68760 Smoking Cigarettes Physician/Medical Due to (or as a consequence of): ettending p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o à 1 Yes 2 No 3 Probably 4 Unknown signed I Records, þ 24b. Were eutopsy findings available prior to completion of ceuse of death? Completed 24e. Was an autopsy certificete 1 ☐ Yes 2 ☐ No Vital 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To of this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division After 5 Pending investigation Attending 1 Natural
2 Accident efter death. 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Thomicide 0 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) To With RD2335 July 13, 1997 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) 9000 Franklin Square Drive Baltimore, Maryland 21237 Daniel Alexander M.D. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State is widson-Randelle Registrar

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122/41

State of Maryland / Department of Health and Mental Hygiene 21233 Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Daath 3. Time of Death Month **Physician** July 10, 1997 Steve VORIAS . /Medicai 9:00 am 4a. Facility Nama (If not institution, giva straat and numbar) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Franklin Square Hospital Center Rosedale
If Under 24 Hrs. Baltimore If Undar 1 Year 8. Date of Birth (Month, Day, Year) Sept. 3, 1923 9. Birthplace (Stata or Foreign Country) Pennsylvania 7. Age (In yrs. last birthday) **Funeral** MM 20F Months Days Hours Min 191-12-5910 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Baltimore 1 Yes 2 No Director Baltimore must be notif 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 8314 Sagramore Road 21237 U.S.A. 238 Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Navar Married 2 Marriad 1□ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th Inspector Steel 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maldan Surnama) Be Michael Vorias Argiro Kariambis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 a nent of Health an ant: If item 27 is a Mrs. Harriet Vorias, wife 8314 Sagramore Road, Baltimore, Md. 21237 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State ě Oak Lawn Cemetery 7-12-97 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Sarvice Licensee 22. Name and Address of Facility any it Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. 21224 no 23a. Part 1. Enter the disease, or complications that caused tha daath. Do not entar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Ceuse (Final disease or condition resulting in death) Pneumonia 3 Weeks Examiner Due to (or as a consequence of) Examiner Cerebrovascular Accident 5 Weeks tran Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of): physician e Atherosclerotic Cardiovascular Disease 10 Years Physician/Medical Due to (or as a consequance of): 50 980 for deteched f Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given In Part I. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Yes 2 No 3 Probably 4 Unknown Chronic Obstructive Pulmonary Disease, Diabetes by Completed 24a. Was an autopsy 24b. Were autopsy findings peen available prior to completion of ceuse of death? Mellitus, Hypothyroidism, Congestive Cardiomyopathy, performed? hes page 2 1□ Yes 25 No 1 ☐ Yes 2 ☐ No Hypertension 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No MInpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation or Attendin effer death. Director: Aft d In by the fur 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours e 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medicel Examiner: On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signatura and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number H35593 July 10, 1997 30. Name and address of parson who complated cause of death (Item 23a) (Type, Print)

State Registrar John Loh M.D.

JUL 1 4 1997

31. Date filed (Month, Day, Year,

1124 Mače Avenue Baltimore, Maryland

21221

altimore, Maryland

Box 68760

P.O.

Records,

Division of Vital

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Appendix and a grant of Tourist THE WALL STORY 10 A STATE OF THE 

\* P. P. Land A. Stein Control of Management (1997)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacadent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July y 1997 Margaret Elizabeth Vaughn 3:00 pm. 4a. Facility Name (If not institution, give street and numbar) 4b. City. Town, or Locetion of Deeth 4c. County of Death 1 Mill Paint Lane, Apt. 1A Owings Mills Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. March Day 14 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign 1 □ M 2 💢 F Maryland 83 215-32-7117 Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Owings Mills 10e, Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1 Mill Paint Lane, Apt. 1A 21117 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give Year or Dates: 13. Wes Dacadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify: 3 Widowad 4 Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Surname) Walter I. Berryman Agnes Leaf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numbar or Rural Route Number, City or Town, State, Zip Code) Nancy Nunn - daughter 1 Mill Paint Lane, Apt. 1A, Owings Mills, Md. 21117 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 20b. Placa of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) LakeView Mem. Park July 14, 1997 Sykesville, Md. 21. Signeture of Funeral Service Licenses 22. Name and Address of Fecility Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills, Md. 21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer failure. List only one cause on each line. Approximata Intervel Between Onset end Death metastatic (a of the Hidney Immadiate Ceuse (Final disease or condition resulting in death) 8 mo Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consaquence of): Due to (or es a consaguence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 3 Probably 4 Unknown 1 ☐ Yas 2 ☐ No 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 | Inpatient Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 1 ☑ Neturel 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) end manner stated. (Check only one) 29b. Signature end title of 29c. Licensa number 29d. Date signed (Month, Day, Year)

The law requires that the death certificate be executed Records, P.O. Box 68760, Division of Vital or Attending Physician: To the Hospital or within 24 hours of To the Funeral D' completely filled i

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Baltimore, Maryland 21216-002

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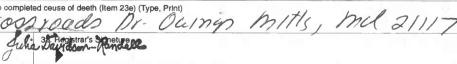
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State of Maryland / Department of Health and Mental Hygiene

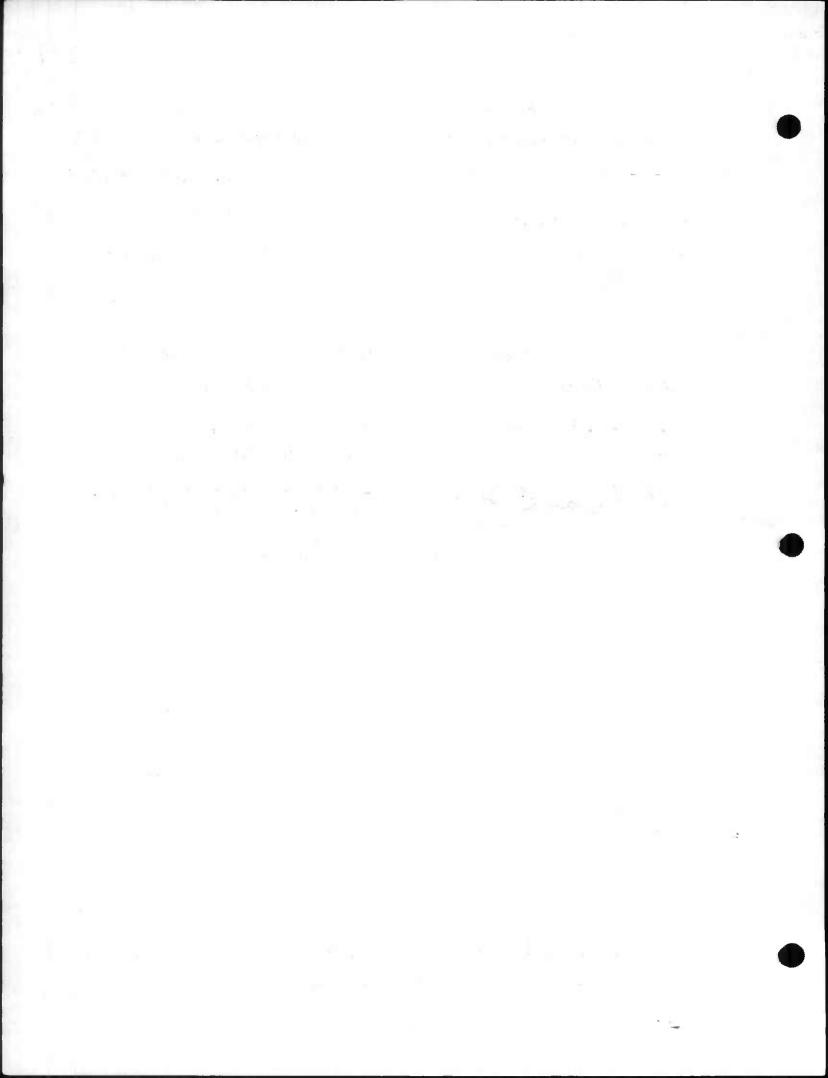
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entricati	2 ☐ Accident investigation	28e. Place of Injur	y - At home, fa	М	1			8f. Location ( City or To	Street and Num wn, Stete)	ber or Run	al Route Number,
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INISION I or Attending after death. Director: After	Certification:	3 ☐ Sulcide 6 ☐ Could not b 4 ☐ Homicide determined	Zoe. Flece Of	Injury - At hom, etc. (Specify)	ie, tarm, str	eet, facto	ory, office			28f. Location City or To	Street wn, Ste	and Numb ate)	er or Rurel	Route Number,
Hospita 4 hours Funeral ely filled	edicai C	29e. Certifier 1 Certifying Ph (Check only one)	ysicien: To the be niner: On the besi end menner	s of exeminetio	edge, death n and/or inv	occurre estigation	d et the tir	me, dete en pinion, dee	d plece, th occurr	end due to the ed et the time,	ceuse date e	(s) end me	nner es ste end due to	eted. the ceuse(s)
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F 3 2 8	In A Vott no						PO	499:	7-		200, L			(997
3		30. Neme end eddress of person who 225- GREE	completed ceuse of	ot deeth (Item 2		Print)	L, T1	M C2 =	. M	D 21	7_0	7	- 10	(1)
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Sta	ate	1111 1 4 100		oner a calculator	- 70	2.00								



State of Maryland / Department of Health and Mental Hygiene

Year

3. Time of Deeth

1 /	Department of Health and	Mental	пуу
	Certificate of Death		P

2. Date of Death

Month

Dey

**Physician** /Medical Examiner 1. Decedent's Name (First, Middle, Last)

Alonzo

Wiley

Gilbert

The law requiras that the death certificate be axecuted physician s the burial Box 68760. 88 P.O. been signed by the a should be detached Records, certificata Vital o Division

07, 1997 JULY 1745PM 4a. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 08-23-64 5. Sociel Security Number If Undar 1 Yaar 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1**□**M 2□ F Days 212-82-9695 32 Yrs. Director Md. Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Insida City Limits than "natural", or items 23a or 28a-f shov the Medical Examinat must be notified at Yes 2□No Director Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 238 5231 Tramore Road 21214 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nearl of Health and Mehal Hygiene.

And I flear 27 is marked other than "natural", or Itema 23 int: If item 27 is marked other than "natural", or other traumatic event, I ma Medical Examination. 12. Wes Decedent Ever in U,S. Armed Forces? ★ 점 Yes 2 □ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexicen, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: Black 1 ☐ Yes 2 ☑ No Specify: by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Telemarketing Sears Dept. Store 12th Grade 17. Fether's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Gilbert L. Wiley Linda 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 21214 19e. Informent's Name/Reletionship (Type, Print) Linda Wiley 5231 Tramor Road Baltimore, Maryland 20b. Plece of Disposition (Nema of cemetary, cramatory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata Md. 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from Stata Garrison Forest VA Cem. 07-14-97 Owings Mills 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue WEST 23a. Pert1. Enter the disease, or complications that caused the daeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heer feilure. List only one cause on each line. Onsat and Death **Physician** /Medicai Immediate Cause (Final disease or condition resulting in death) a Blunt Force Inger of Head and Multiple Cutting Wounds Examiner Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated avants resulting in death) Lest Due to (or as a consequence of): Dua to (or as a consaquance of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown þ Be Completed 24b. Were eutopsy findings eveilable prior to completion of causa of deeth? 24e. Wes an autopsy performed? ANO 2□ No 25. Wes case referred to medical 28. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 XInpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To 1∰Yes 2 No 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred subject beaten and cut 5 Pending invastigation 1 Netural Injury 218 AM 1 Yes 2 No 2 Accident 7/6/97 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) GO BELG an Ace Ba Himere I Me 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 49-Homicide Shey To the Hospital within 24 hours of To the Funeral completely filled 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner steted. Medical 29a. Certifier (Check only 29b. Signature and title of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) O.C.M.E. JULY 09, 1997 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) Dennis J. (1) 31. Date filed (Month, Day, Year) 111 Penn Street, Baltimore, Maryland 21201

Legistrar's Signetura

State Registrar

JIL 141997

State of Maryland / Department of Health and Mental Hygiene

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	•		5 ·		4	C	ertifica	te of	Death			Reg. No.		los I for	. 0 5
	- 50 · · ·		1. Decedent's Neme (First, Middla, La	st)							2. Deta of Da Month	ath Dey	Vans		of Death
	Physici /Medi		Blanche Iren	ne Wri	ght						July	6, 19	97	1.00	) YW
j	Exami		4a. Fecility Neme (If not Institution, giv		umber)						cation of Deeth				
			17105 York Roa		,		1		Park			Balt	ımor	e	
	Funeral Director		5. Social Security Number 6. S  216-98-4903	ex □M 2ŽŽF	7. Age (In y	rs. lest birthde Yrs.	Months	Deys		Min.	8. Deta of Bin (Month, Da March 2	1922 4, 1922	9. Birthp Cour Ma	piaca (State try) rylar	or Foreign nd
	pue *		10a. Stete 10b. County		10c.	City, Town or	Location						1	0d. inside (	City Limits
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	ter death with the Merylen Heme 23s or 28s-f show Instrument be notified at		17105 York F				101. 2	21]	L20			U.S.A	•		
020	should be filed within 72 hours effer death with the Meryland nd Mentel Hygiene. merkad other than "natural", or Itema 23a or 28a-f show umatic ayant, the Medical Eventines must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Merried  3 ☒ Widowed 4 □ Divorced	Armed F	2.⊠No ive	U,S. 1:	If Yes, sp	ecify Cul	Hispanic Ori ban, Mexicar Specify:	n, Puarto I	cify Yes or No Rican, atc.)		e - Amaric ck, White, : Wh		
Maryland 21215-0020	d within 72 hours eff piene. r then "natural", or the Medical Exam	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de complated,	) (1-4or 5+)	(Gi		ork done usa retin	petion during mos ed)	at of working	ng	16b. Kind of B			
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pu	I be file ntel Hyg ad other avant,	Be	17. Fathar's Nama (First, Middla, Last)						The second second			Meiden Sumen	7a)		
7	Men Merka Merka	은	Walter S. Ba								. Whe				
			W. Herbert Wrig			P.C	. Во	x 6				m, PA			
Baltimore,	permit. Peges 1 and 2 Department of Health s important: If frem 27 is any injury or other tra once.		20e. Method of Disposition  1 ☑ Buriel 2 ☐ Cremetion 3 ☐  4 ☐ Donetion 5 ☐ Office (Specifi		State D1	Plece of Dis cometery, c ulanev emoria	position (Note that the positi	me of other plants of the control of	ns	Jul	y 9, 997	Zimon.			
Balti	permit. Departminportal		21. Signature of Funeral Service Licen	le ver	Lazar		22. Name 6	nd Addr Ha	ess of Fecili rtens	stei	n Mort	uary,			
			23a. Fary . Enter the disease, or com-	plications thet	caused the de							edom, I	A 1	Approxima	ata
	Physician		shock or heart feilure. List only	one ceuse on									1	Intervel Be Onsat and	tween I Deeth
П	/Medical		Immediate Cause (Finei disaese or condition		(DUM	ar a	nter 1	Dux	USO					yea	0
п	Examiner		resulting in death)	a	Due to	ar a coresecons oscion	sequence of	):						you	•
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ó	exacute en end riel-tran	Examiner	Sequentially list conditions, if eny, leading to immedieta causa. Enter Underlying Cause (Diseese or injury	D. ————	Due to	(or es e cons	equence of	):						-	
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Вох	ath ce	Physician/		d											
0	the death y the etter sched for u	ysic	Pert ii. Other significant conditions of	ontributing to d	leath but not r	esulting in the	underlying	causa g	ivan in Part I	l.	23b. Did (	tobacco use co	ntribute to	the cause	of death?
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o	Phys erel d	n: To	27. Magner of Deeth	28a. Data	of Injury	☐ ER/Outpat 28b. Time	of	28c. Inju		ursing Hon	-	dence 6 Oth		7)	
0	Attending or death. actor: After by the fune	atlo	1 Naturel 5 ☐ Panding 2 ☐ Accident Investigation		nth, Dey Year)	Injun	M		onk? ]Yas 2 □	No					
Division of	i or Atta after de Diracto d in by th	Certification:	3 Suicida 6 Could not be determined	28a. Place	e of injury - At ling, atc. (Spe	home, farm,	street, facto	ry, office		2	28f. Location (3 City or Tox	Street end Numb vn, Stete)	er or Rura	I Routa Nui	mber,
	To the Hospital or Attanding Ph within 24 hours after death.  To the Funeral Diractor: After thi complately filled in by the funeral	edical C	29a. Certifier (Check only one) Certifying Ph	liner: On the b	best of my k besis of axami	nowledga, da nation and/or	ath occurred investigetion	d at tha t n, in my	ima, date an opinion, dee	d plece, e	end due to that ad et the time,	ceuse(s) end ma dete end place,	annar es si and due to	eted. the ceuse	(s)
	To the To the comp	Me	29b. Signatura and title of certifiar	~ M			25	C. Licen	se number	2		29d. Date signe	d (Month,	Day, Year)	4.2
			30. Neme end address of person who		se of deeth (It	em 23e) (Tvp	e, Print)			1		,	. /		
			Mark Lamos, MD		illing			t V	alley	y, M	D				
	Sta	te	31. Date filed (Month, Dey, Year)	32. F	Registrer's Sig	neture									
	Registr	ar	JUL 1 4 1	997	Julian	avidson-	Pandela	la.							

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/Medical Examiner Examiner buriel-transit end physicien the ate hes been signed by pege 2 should be detect certificate hes

**Physician** 

/Medical

Examiner

10a State

MD.

**Funeral** 

Director

na 23a or 28a-f show must be notified at

Name 23a

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permit. Pages 1 and 2 should be Department of Health and Mental it Important: If Item 27 is marked on

**Physician** 

Saltimore, Marylan

Director

Funeral

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Completed

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To the Hospital or Attending Physician: within 24 hours effer deeth.

To the Funeral Director: Affer this certifical completely filled in by the funeral director;

State Registrar

Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. by Be Completed 25. Was casa raferred to medical 1 Yes 2 No 2 Medical Certification: 27. Manner of Daath 1 Natural
2 Accidant 3 Suicide 4 Homicide Certifying Phystcian: To the best of my knowledge, death occurred at tha tima, data and plece, and dua to tha causa(s) and mannar as steted.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the causa(s) and mannar steted. 29e. Certifian 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year)

Baltimore MD 21201

10 Grppni

30. Nama and addrass of person who completed causa of daath (Itam 23e) (Type, Print)

Scott Huber M.D.

JUL 1 4 1997

31. Data filed (Month, Day, Yaar)

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State of Maryland / Department of Health and Mental Hygiene 97

							Cei	rtificate of	Death	1		Reg. No.		
		.111	1. Decedent's Neme (First, Mi	ddle, Last)							2. Dete of De	ath	Vana	3. Time of the
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	Funeral Director	Г	5. Sociel Security Number 213-20-8347	6. Sex		ge (In yrs. lest l 72	birthdey) Yrs.	If Under 1 Yea Months Dey	r If Under	Min.	8. Date of Bir (Month, Da April	<sup>th</sup> 11 1925	9. Birthol Count	ece (Stete or Foreign try) aryland
	the Maryland 28a-f show notified at	tor	Usuel Residence of Decedent  10e. State 10b. Cou	nty N/A	_	10c. City, To	own or Lo		altimo	re C				Od. Inside City Limits 1 X Yes 2 □ No
-	with the M Se or 28s-f It be notifie	al Director	10e. Street end Number	5001 Gle	noak	Avenue		10f. Zip Code		214		10g. Citizen of V		
020	HW)	by Furfer	11. Marital Status 1 □ Never Married 2 💢 M 3 □ Widowed 4 □ Divord	arried 1	es Deceden ned Forces Yes 2 fes, Give ar or Dates:	No		Wes Decedent of If Yes, specify Cu			pecify Yes or No Rican, etc.)		a - America k, White, e	an Indian,
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	s 1 and 2 should if Health and Mer Hem 27 is marks other traumatic		Elizabeth E.  20e. Method of Disposition	Zizware	( ( W ]	fe)		1 Glenoa sition (Name of	k Ave.	. Ba		e, Maryl		21214
Baltimore,	8 = 5 B		1 ⊠ Buriel 2 ☐ Crematic 4 ☐ Donetion 5 ☐ Other	(Specify)		More]	ery, crer land	Memoria	,	< 7/1	Date 14/97	Baltimo		Maryland
Ball	permit. Pa Departmen Important any injury snce.		21. Signeture of Funeral Servi	ce Licensee	Iton J	Knight 3	1	2. Name end Add		Let		. Ruck,		1214
	- 170		23e. Pert1. Enter the diseese, shock, or heart feilure. L	or complications	that cause	d the eath. De	o not ent	er the mode of dy	ing, such es	cardiac	or respiretory e	rrest,		Approximete Intervel Between
	Physician /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in deeth)	θ		SEP S.	15							Onset end Death
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.09	icate be executed physician and s the burial-transit	ai Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events	<b>S</b> b		Due to (or es	e conseq	juence of):						
Box 68760,	eath certificate attending phys for use es the	in/Medical	resulting in deeth) Lest	d		Due to (or es e	conseq	uence of):						
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Vital	Physician: The rthis certificate and director, pag	Be	25. Was case referred to medi examiner?	-						e of Deat	h (Check only o	ne)		
of	Physic this or ral dire	P	1 ☐ Yes 2 No	Hospite	1 EU Inpati	ent 2 ER/C	Outpetien	I SLI DON		ursing Ho	ome 5 Resid	denca 6 □Oth	er (Specify	)
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Division	al or Attendis s after death. I Director: A sd in by the fu	Certification:	3 Suicide 6 Cou 4 Homicide dete	d not be mined 28e	Plece of In building, e	jury - At home, tc. (Specify)	ferm, str	eet, factory, office	1		28f. Location (S City or Tox	Street end Numb vn, Stete)	er or Rurel	Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in the	edicai (	29a. Certifier 1 ☐ Certification (Check only one) 1 ☐ Certification (Check only one)	al Examiner: Or	To the best the basis of d manner st	of exeminetion e	ge, deeth and/or inv	occurred et the restigetion, in my	time, date er opinion, dea	nd placa, ath occur	end due to the red et the time,	ceuse(s) end ma dete end place,	inner es ste end due to	eted. the ceuse(s)
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	10		30. Name and eddress of person	on who complete	- 4			Print)						239-2995
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State of Maryland / Department of Health and Mental Hygiene Q 7

					Cert	ificate of	Death		Reg. No.	1 6	1144
			1. Decedent's Name (First, Middle, Li	ast)				2. Dete of De	eeth	Veer	3. Time of Death
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	Funeral			Sex 7. Age (in yrs. le		If Under 1 Year Months Deys		8. Date of Bi (Month, D	rth ev. Year)		ce (Stete or Foreign
ı	Director		219-20-9949	1□ M 2ŪXF 78	Yrs.		1.02.0	08-13-	1918	MARY	LAND
	pu *		Usual Residence of Decedent  10a. State 10b. County	10a City	Town or Loc	ation				140	d 1id- Oik-1 iis-
	sho	-								100	d. Inside City Limits  1 ☐ Yes 2 ☑ No
	he M	Director		RUNDEL PA	ASADENA	_					**
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	be filed with tal Hygiene. d other than		17. Fether's Name (First, Middle, Las		110111	3. 11 11 (12)	18. Mother's Nen	ne (First, Middle	, Maiden Suman		
Maryland	0 0 0 0	o Be	ARTHUR RAYMOND				CATHERI		ANNA		MPER
2	d 2 should be thend Mental 7 is marked of traumatic ever	2	19a. Informent's Name/Reletionship		19h Mailing	Address (Stree	t end Number or Ru				
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	ortan Srtan Injur		4 ☐ Donation 5 ☐ Other (Special Service Lice			Name end Addre		720/31	GDEN DO	, KKIE,	-FID
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I.		١.,	23a. Part1. Early the Adams, or com shook or heart failure. List only	one ceuse on each line.	Do not ente	r trie mode of dy	ing, such es cardied	or respiretory e	errest,	1	Approximete Intervel Between Onset end Deeth
*	Physiclan /Medical		Immediete Ceuse (Final	^	1						A
	Examiner		disease or condition resulting in deeth)	. SMALL CE	لا لا	WG	CANCE				4 weeks
		-		Due to (or	es e consequ	ence of):					
	nsit	Examiner		b. ————————————————————————————————————							
-6	lew requires that the death certificate be executed as been signed by the attending physician and a should be deteched for use as the burial-trensit	Exa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	es e consequ	ence of):				1	
68760,	sicie burd		Cause (Disease or injury thet initieted events	C		anaa afi:					
89	fficet g phy ss the	Medical	resulting in deeth) Lest	Due to (or o	es e consequ	ence or):					
Box	eath cert ettending I for use	2		d							
Ď	d for	Physician/	Pert II. Other significant conditions	contributing to death but not resul	ting in the uni	derhving cause ni	ven in Pert I	23h Did	toberco use co	ntribute to (	the cause of death?
P.0	requires that the de been signed by the should be deteched	hys			_		voir air t oit t.		Yes 2□ No		ably 4 Unknow
	s thet	by P	שבני יינ	IN THROM	13051	5			100 1010	0	,
Vital Records,	quire; n sig uld b								en eutopsy		e autopsy findings lable prior to
8	w rec	let						реп	ormed?	com	pletion of cause eeth?
8	0 - 0	Completed						40	Yes 20 No	10	
Ø		Ö	25. Was case referred to medical				00 81			- '0	165 240110
5		00	exeminer?	Hospital:	D/Out-ations	a□ po₄ Ot	26. Plece of Dee			(Cif-i	
o	Phys r this aral d	: To	27. Manper of Deeth		R/Outpetient 28b. Time of				Idence 6 Oth how injury occur		
o	Attending r deeth. actor: After by the fune	tior	1 Neturel 5 ☐ Pending investigation	(Month, Dey Year)	Injury	28c. Inju Wo M 1	ork? ]Yes 2∐No				
Division	deeth. ctor: A y the fi	fica	3 ☐ Suicide 6 ☐ Could not b	De Con Diagnost Inium. At hom	ne. farm. stre	et, factory, office		28f. Location	(Street end Numb	er or Rurel	Route Number,
2	Oire Direction	Certification:	4 ☐ Homicide	building, etc. (Specify)	)	.,,		City or To	wn, State)		
	Hospital 24 hours Funeral stely filled		29a. Certifier Certifying Pt	nysician: To the best of my know	tedge, deeth	occurred et the ti	ime, date end place	end due to the	ceuse(s) end me	enner es ste	eted.
	To the Hospital or Attending I within 24 hours efter deeth.  To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Example one)	miner: On the basis of examinetic and menner steted.	on end/or inve	estigation, in my	opinion, deeth occu	rred et the time	, dete end place,	end due to t	the cause(s)
	within To the	Me	29b. Signeture end title of certifier			29c. Licen	se number		29d. Date signe	d (Month, D	ay, Year)
	F > F 0		ASA	am		DA	3977	-	TUE !	15	1997
,			30. Name end eddress of person who	completed cause of death (Item	23e) (Type D	(rint)	3111		JUNC 0		
			AAYda.	STI ANTA COL	HADIT	n- Na	vE. GLOV	Rical	15 M	D >	plat.
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	nte .I.N.I.I.	12 0.4	TIVE	D War	- ''		,001.
	Registi		1111 64	1997 Julia Ke	10. 90	2.00					
DM	MH 16 Pey 6/9	-	JUL 01	133/ June Day	Actor - 16	HI LAURING					

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97

						,		ificate of	Death		Reg. No.	, ,	11270
ĺ	Physici	an	1. Decedent's Name	(First, Middle, La	ist)					2. Date of De Month		Year	3. Time of Death
J	/Medic		VER				A	<b>IGELLATTA</b>		JUNE	30, 1	997	8:42 PM
9	Examir	er	4a. Facility Name (If		the person in the	)				Location of Death	DK 20.77		
H			NORTH ARUN  5. Social Security Nu	mhor 6 G	Cov 7 A	ge (In yrs. la	st hirthday)	If Under 1 Yea	GLEN BURN	IIE	ANNE	ARUNDE	
	Funeral Director		234-34-1		1 M 2 F	73	Yrs.	Months Days		NOV DE	y, Year 923	Cawa	lace (State or Foreign
	pu *		Usual Residence of D	Decedent 10b. County		10a City	Town or Loca	ation					
	Aaryle f sho	ō	MD	Anne Ar	rundel.		Pasade					11	0d. Inside City Limits 1 ☐ Yes 2 → No
	28a-	Director	10e. Street and Num	ber				10f. Zip Code			10g. Citizen of V	What Cour	
	within 72 hours effer death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examine must be notified at	a Di	8387 Boo	lkin Ave	nue			211	22		US		.,
	r dea	Funeral	11. Marital Status		12. Was Decedent Armed Forces	Ever in U,S	i. 13. W	as Decedent of Yes, specify Cu	Hispanic Origin? (: ban, Mexican, Pue	Specify Yes or No	- 14. Raci	a - Americ	
20	rs efte	by Fi	1 ☐ Never Marrie 3 🗗 Widowed 4		1 Yes 2 The Yes, Give Year or Dates:	No		□Yes 2 No			Specify		white
2-00	2 hou atural	ted	1	15. Decadent's E	ducation		16e. Decede	nt's Usual Occi	petion		16b. Kind of Bu		
218	within 72 he ene. than "natur he Madical	Completed	(Specify Elementery/Second	y o <i>nly highest gre</i> dary (0-12)	ede completed) College (1-4or	5+)			upetion e during most of wo ed)	orking			
121	the time of the same						Homema	ker			Own Ho		
Maryland 21215-0020	b d lal	Be	17. Father's Name (F	Carver	)					me (First, Middle, (Claytor		(e)	
aryl	d 2 should be the and Menta 7 is marked traumatic as	P_	19a. Informant's Nan	ne/Relationship (	Type, Print)		19b. Mailing	Address (Stree	et end Number or F			State. Zio	Code)
	tra tra		Frank Ar	ngellatt	a-son		Pasac	lena MD	21122			,	
ore	S		20a. Method of Dispo		Removal from State	20b. Pla	nce of Disposi metery, creme	tion (Name of etory or other piermorial	ace)	Date	20c. Location -		
Baltimore,	0 >		4 ☐ Donation 5	Other (Specif	(y)	Sur	-			07/03	Cumber	:Land	MD
Bal	permit. Pe Depertmen Important: any Injury once.		21. Signature of Fund	aral Service Licer	Mccx	1/1	22.1	"Scarpe Cumber	III'FUner land MD 2	ral Home 21502			
	-		23a. Pert Enter the	disease, or comfailure. List only	plications thet cause one cause on each I	d the death. ine.	Do not enter	the mode of dy	ring, such as cardia	c or respiratory a	rest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (F	inal			0 /	7					Onset and Death
1	Examiner		disease or condition resulting in death)	· iai	a chrom	e ner	nel vo	arline					1 year
		ner			Digh	Due to (or	as a conseque	enca ot):				1	years
	ecuted and transi	Examiner	Sequentially list cond	ditions,	b	Due to (or	as a consequ	enca of):					Just
60,	be ex ician a		Sequentially list condif any, leading to immoduse. Enter Underly Cause (Disease or Inthat initiated events	ying ijury	C		-					1	
68760,	tificete be executed ig physician and es the buriel-transit	edicai	resulting in death) La	.st		Due to (or a	as a conseque	ence of):					
Box		Physician/M			d	-							
	death cei he attendir	sicia	Part II. Other signific	ant conditions o	contributing to death b	out not result	ting in the und	lerlying cause g	iven In Part I.	23b. Did 1	lobacco use cor	ntribute to	the cause of death?
P.0	es that the death cer igned by the attendin be detached for use	Phy	Carelin	nas cul	las disio	1 la	'x2 6	44 1000	4	1 🗆	Yes 2 No	3 Prob	bably 4 Unknown
ds,	requires the	d by						morg	Δ	240 Was	en autopsy	24h Wa	ere eutopsy findings
Record		Completed	intrucia	mal o	neugan	N	yeuth	mordi	en		rmed?	cor	ailable prior to mpletion of cause deeth?
	sician: The law certificate has b lirector, pege 2 s	mo			•		J.	•		101	res 2 No		Yes -2 No
of Vital	lan: T	BeC	25. Was case referre examiner?	d to medical					26. Place of De	ath (Check only o			7.00 250.0
of V	> 00 0	2	1 ☐ Yes 2 N	0	Hospitel: 1 ☐ Inpati	ent 2 E	R/Outpatient	3/25 DUA		Home 5 ☐ Resid	dence 6 Oth	er (Specify	1)
	ding P. After t	ion:	27. Menner of Death 1 Natural	5 Pending	28e. Date of Inju (Month, De		28b. Time of Injury	28c. Inj		28d. Describe i	now injury occurr	ed	
Division	or Attending effer deeth. Director: Afte d in by the fune	ficat	2 ☐ Accident 3 ☐ Suicide	investigation  6 Could not be determined	e One Place of In	iury - At hom	ne. farm. stree		Yes 2 No	28f. Location (S	Street and Numb	er or Rura	l Route Number.
Ö	s efter	Certification:	4 ☐ Homicide	determined		c. (Specify)		.,,		City or Tov			
	To the Hospital or Attending Ph within 24 hours effer deeth. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1	Certifying Ph	nysician: To the best niper: On the basis o	of my knowl	edge, death o	occurred at the i	ime, date and plac	e, and due to the	cause(s) and ma	nner es st	eted.
	the Ithe Ithe E	Medi	one) 29b. Signature and til		and manner st	ated.	and or mye	-					
		-1	X	neu 1	Laws	am		Α.	22443		29d. Date signed	(Month, L	9 7
	3		30. Name end addres	is of person wha	eompleted cause of	death (Item 3	23 <b>d</b> ) (Tvne P	1-		0	July 1	) ( [	. /
	MAS		STUART	JACUAS	m). 3		באוקבי	Drive	Glen	Burnie,	MD. 2	106/	
	Sta	te	31. Date filed (Month	Day Year 195	32 Regist	ar's Signatu	ire Light		4				

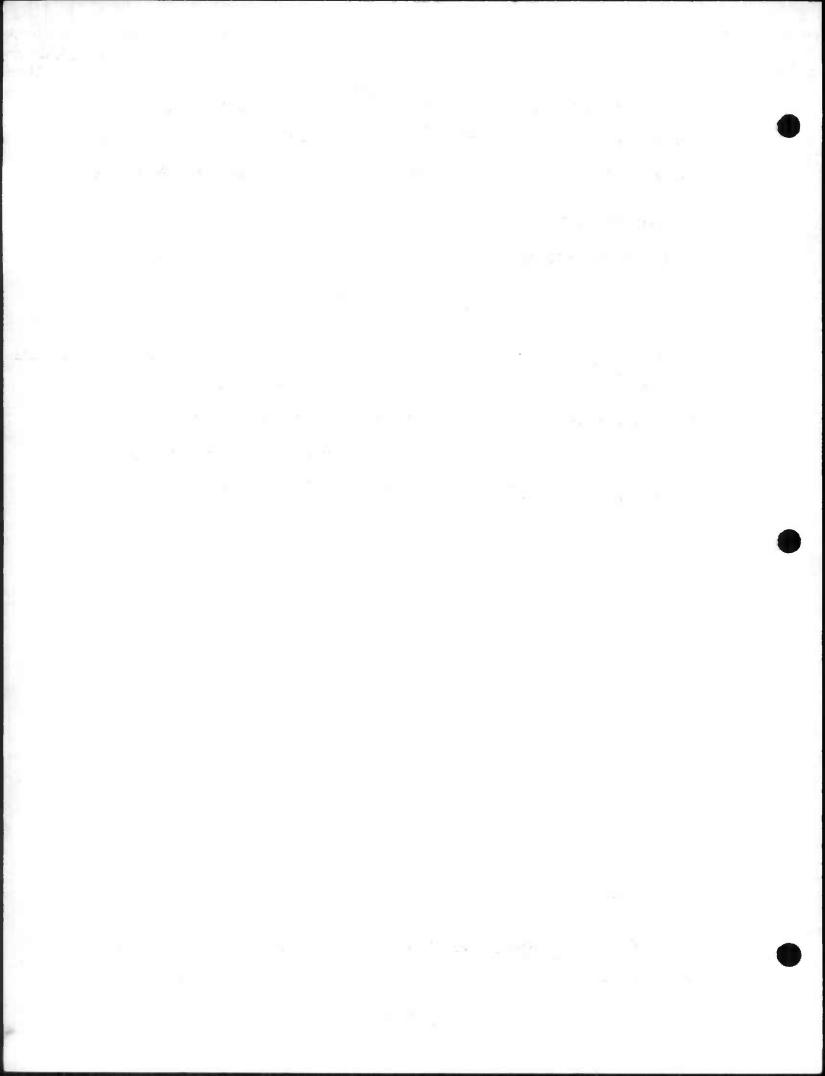
		Certificate of Death		Reg. No.	1 21244
Physi /Med		Jeanne Deery Beck	2. Dete of De Month June	Dey	997 3:00PM
Funera Directo	iner il	4e. Fecility Name (If not institution, give street and number)  556 Ferry Point Road  5. Sociel Security Number  6. Sex 1 M 2 XF  7. Age (In yrs. lest birthdey) Months Deys Hours Min.	8. Date of Bir (Month, De	Unit	of Deeth  ed States  9. Birthplace (State or Forei Country)  Delaware
Marylend H show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limit
with the	al Director			10g. Citizen of V	Whet Country? States
5-UUZU 72 hours after death with the Marylend natural', or items 23a or 28a-f show	by Funeral	3 ☐ Widowed 4 ☐ Divorced Yeer or Dates:	cify Yes or No Rican, etc.)		ee - American Indian, ck, White, etc.
d within glene.	Be Completed	17. Fether's Neme (First, Middle, Last)  18. Mother's Name		Retail/	usiness/industry Childrens Clothing
Maryia 12 should I h and Meni 'Is marked Iraumatic	70	William A. Deery  19a. Informent's Name/Reletionship (Type, Print)  19b. Mailing Address (Street and Number or Rurel)		er, City or Town,	
Dallimore, Maryland semit. Pages 1 end 2 should be file Department of Health and Mental Hy mortant: If item 27 is marked other in highly or other traumatic event, once.		Dr. Edward Beck (Husband)  20a. Method of Disposition  1 Burial 2 \( \) Cremation 3 \( \) Removal from State  4 \( \) Donetion 5 \( \) Other (Specify)  20b. Place of Disposition (Neme of cemetery, cremetory or other place)	Date	20c. Location -	City or Town, State
permit. P Departme Importan any Injur	(	21. Squature of Funeral Service Licensee  22. Name and Address of Fecility John 147 Duke of Gloucest	M. Tay	lor Fun	od,Maryland eral Home, Ind lis. MD21401
Physician /Medical Examiner		23a. Pent1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or shock, or heart feilure. List only one ceuse on each line.  Immediate Ceuse (Final disease or condition resulting in deeth)  Bue to (or es a consequence of):	respiretory e	rest,	Approximete Intervel Between Onset end Deeth
sath certificate be executed attending physician and for use es the burial-transit	n/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last  Due to (or es e consequence of):  Due to (or es e consequence of):  Due to (or es e consequence of):			
d by the	/ Physiclan/M	Part II. Other eignificent conditione contributing to death but not resulting in the underlying ceuse given In Pert I.		obacco use cor Yes 2 No	ntribute to the cause of deeth
Iclan: The law requires the certificate hes been signed rector, page 2 should be or	Completed by		24e. Wes perfo	en eutopsy rmed?	24b. Were eutopsy findings eveilable prior to completion of cause of deeth?
	Be Con	25. Wes case referred to medical 26. Plece of Death	(Check only o		1 ☐ Yes 2 ☐ No
ig Phys ter this neral di	Certification: To	Hospital: 1   Inpatient 2   ER/Outpetient 3   DOA   Other: 4   Nursing Hom	e 5 Resid 8d. Describe h	lence 6 Dothe	ed
To the Hospital or Attendin within 24 hours effer death. To the Funeral Director: Af completely filled in by the fu	edical Certifi	4 Homicide  288. Piece of Injury - At nome, ferm, street, factory, office building, etc. (Specify)  29a. Certifier (Check only 2 Medical Examiner: On the basis of examination end/or investigation in my onintendent accurred.	City or Tow	m, Stete)	er or Rural Route Number,  enner es steted.  end due to the cause(s)
To the I	Med	29b. Signature and title of certifier  M.D.  29c. License number  DA 94465			d (Month, Dey, Yeer)
		30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)  Ann C. Mayey, M.D., 900 Bert gate Rd,  31. Dete filed (Month, Day, Year)  32. Begistrer's Signeture	uu>b	olis, n	nd ayor
St Regist	ate	31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture			

4... THE REPORT OF THE PROPERTY OF ter to the first of the control of the second of the secon 

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				otato of Maryla		Certificate of		vioritai rij	Reg. No.	•	fine I fine	70
г	Dharaini		1. Decedent's Nama (First, Middla, L	ast)				2. Deta of De		Yaar	3. Tima o	of Death
	Physici /Medi		DANIEL MAC	BROWN				JUNE 2	0 1997	Talati	12:50	) pm
	Examir		4a. Facility Neme (If not institution, g	ive street and number)			4b. City, Town, or	Location of Deal	th 4c. County	of Deeth		
			CHESAPEAKE MANO	R NURSING CENT	ΓER		ARNOLD		ANNE A	ARUND	EL	
	Funeral Director		214-56-1019	Sex 7. Age (In yr. 15) 15) 1 4 7		hday) If Under 1 Yee Yrs. Months Days		8. Data of Bi (Month, Do JAN 1	rth ay, <i>Year)</i> 8 1950	9. Birthp Cour MARY	piece (State htry) LAND	or Foreign
	pu .		Usual Rasidance of Decedent  10a. Stata 10b. County	100.0	ih. Tour	or Location						March Inches
	sho	5									10d. Inside C	2 □ No
	the A	Funeral Director	MARYLAND ANNE ARU  10e. Street end Number	NDEL AND	NAPOI	10f. Zlp Code			10g. Citizan of	What Cour		
	With Page	ā		DD 4 0 E						rviiai Cour	nuyr	
	s 23	era	1115 EASTPORT TE	RRACE 12. Was Dacedant Evar In	US	2140	<u> </u>	necity Vas or N	US 14 Bec	e - Amarlo	can Indian,	
0	fter d	듄	1 XNevar Married 2 Married	Armad Forces?	0,0.	13. Wes Decedent of If Yas, specify Cu	ban, Maxican, Puart	o Rican, atc.)	Bia	ck, Whita,		
020	urs e	by	3 ☐ Widowed 4 ☐ Divorced	1 XYas 2 □ No If Yas, Giva Year or Datas 1969 -	-72	1□ Yes 2□xNo	Specify:		Specif	y: BLA	CK	
21215-0020	be filed within 72 hours efter deeth with the Meryland ntal Hyglene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be northed at		15. Decedent's E	Education		Decedant's Usuai Occi	upation		16b. Kind of B			
215	within 7 ene. than "n he Medi	Completed	(Specify only highest gi	rada compiatad)  Collega (1-4or 5+)	$\dashv$	Decedant's Usuai Occi (Giva kind of work don- lifa. DO NOT use ratir	a during most of wor ed)	king				
	od wil	Son	10th	00	P	ACKER			UNITED	MOVI	NG & S	TORAG
pu	be filed ital Hygi d other event, i	Be (	17. Fethar's Nama (First, Middla, Las	t)			18. Mother's Nan	ne (First, Middle	, Maidan Suman	na)		
yla	should bind Manta	To	MACK A. BROWN				SUS	AN SIMM	S			
Maryland	permit. Pagas 1 and 2 should I Department of Health and Man Important: If Item 27 is market any injury or other traumatic once.		19a. Informant's Name/Ralationship MARY WATKINS (COU			Mailing Addrass (Strate 21 EASTPOR						
Je,	of Her of Her othe		20a. Mathod of Disposition		Place of	Disposition (Nama of y, cramatory or other pi	lace)	Data	20c. Location	- City or To	own, State	
Ĕ	Pagas nant of nt: If ite		1 ☑ Burial 2 ☐ Cramation 3 l 4 ☐ Donation 5 ☐ Othar (Spec		RYLAN	D VETERAN	CEMETERY	6/30/97	CROWNS	/ULLE	, MD.	
Baltimore,	permit. Departmimporta		21. Signetura of Funaral Sarvice Lice			22. Nama and Add WM • REESE	rass of Facility	ORTIIARV	РΛ			
Ш	80 5 5 8		Harry 1	J. Leese	_	821 WEST						
			23a. Part1. Enter tha disaase, or con shock, or haart failura. List only	npilications that causad tha day	ath. Do n						Approxima intarval Ba	ta twaan
8	Physician					- /					Onsat and	Death
u	/Medical		Immediata Causa (Finai disaase or condition	Cereu	Len	a s x	- wer			4	3 Mer	M
	Examiner	L	rasulting in death)	Due to	(or as a c	onsequance of):			(	1	0 6-	
	sit ad	ine		Heguns	4	mun	w defee	energ	Lyndy	we.	de	313
	tificete be axecuted ig physicien end as the burial-trensit	Examiner	Sequentially list conditions, if any, laading to immadiate cause. Enter Undarlying	Due to	(or as a c	onsequanca of):			0			
68760,	be ay icien buria		cause. Enter Undarlying Causa (Disaasa or injury that initiated evants	C								
387	phys the	edicai	resulting in daath) Last	Due to	or es a c	onsaquence of):				į		
	ding ding	_		d								
Вох	eath ettar	ciar										
P.O.	requires thet the death cer seen signed by the ettandin should be detached for use	Physician/M	Part II. Other significant conditions	contributing to death but not re	isulting in	tha undariying causa g	given in Part I.		tobecco use co			4
0	thet hed b							10	Yes 20 No	3 Pro	bably 4□	Unknown
ds	w requires thet been signed to should be det	d by						24a. Wes	an autopsy	24b. W	ara autopsy	findings
00	> 20	iete						perf	ormad?	CO	ailable prior mplation of daath?	
Re	S S	Completed						40	A A			1 A 1 -
a	vician: The lav certificate has rector, page 2	e Cc	25. Was casa rafarred to medical				00 Bt - 1B	1 🗆		11.	□Yas 2□	NO NO
Division of Vital Records,	sicia	8	axaminar?	Hospital:	7 50/0	0 000	26. Place of Dea			(0	4.1	
o	Phys r this oral d	: To	27. Mannar of Death	1 ☐ Inpatient 2	☐ ER/Out 28b. T	1 - 1			idanca 8 Oth		(y)	
on	ding Th.	tior	1 X Naturai 5 Panding 2 Accidant investigation	(Month, Day Year)		njury W	onk? ⊒Yas 2⊟No					
<u>ISI</u>	Atten ctor	fica	3 Suicida 6 Could not	ba 28a. Place of Injury - At		rm, straat, tactory, office	B	28f. Location	Straat and Numi	ber or Run	al Routa Nun	n <i>ber</i> ,
ă	ii or Attending P safter death. I Director: After t d in by the funers	Certification:	4 ☐ Homicida	building, etc. (Spec	eify)			City or To	wn, Stata)			
	To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate ha completaly filled in by the funeral director, page	edicai C	(Check only 2 Medical Exa	hysicien: To tha best of my kr miner: On the basis of axamir	owledga, ation and	death occurred at the Vor Invastigation, in my	time, date and place	, and dua to tha rred at the time,	causa(s) and made and place,	annar as s and due to	tated. o the cause(	s)
	the the	Med	one) 29b. Signatura and titla of certifiar	and manner stated.		29c Lices	nse number	1	29d. Data signe	nd (Month	Day Voor	
	<b>5</b> ₹ 5 8		1 0	1 1000	n.	~	D ( C /.					
			Wynoem				21007		7-			
			30. Nema end addrass of parson who	complated causa of death (lite	m 23a) (	Type, Print)	PASADRA	AM	0 2112	2		
	- 01	•	31. Data filed (Month, Day, Year)	32. Registrer's Sign			,	/		`		
	Sta Registr		JUL 0 2 19			70.4.0						
DH	MH 16 Ray 6/9	_	702 0 70	- January	(2/10)	Honore						

DHMH 16 Rav 6/95



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 flours after death. Page 6 may be retained by the hospital or attending physician.

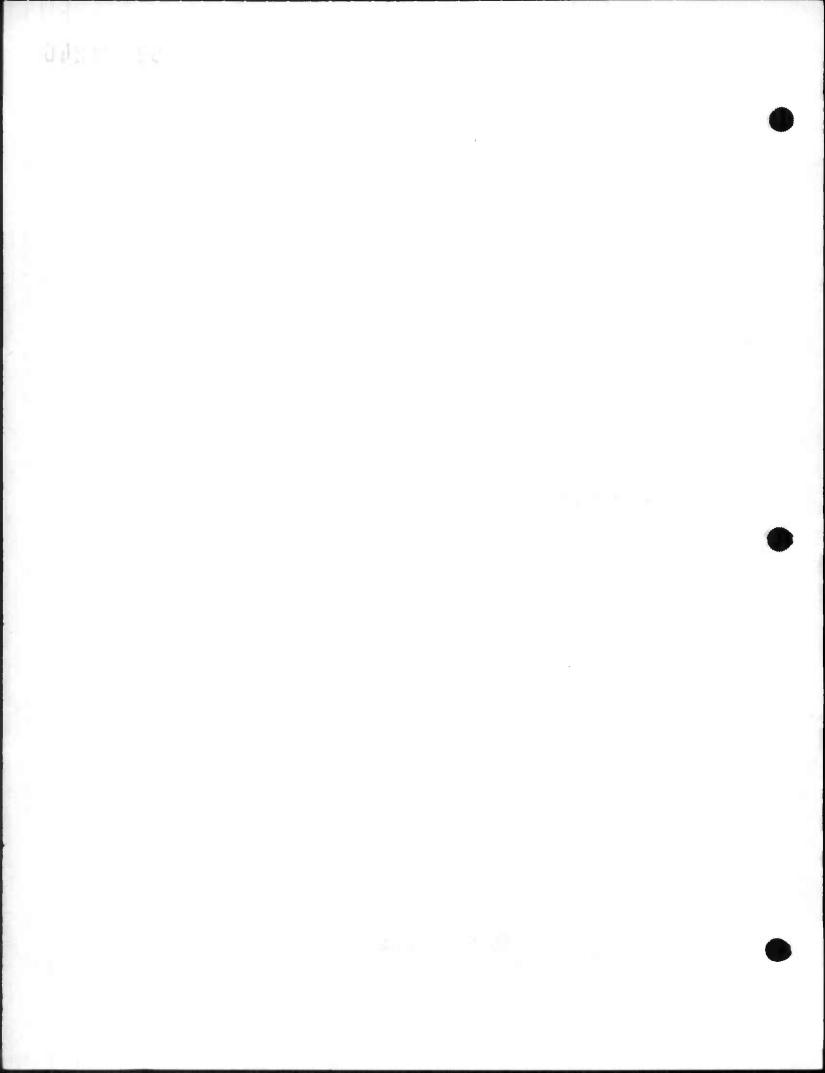
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR 1 - STATE REGISTRAR

### STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO.

	REGISTRAR		CERTIFIC	AIE OF	DEATH	REG.	NO.							
	1. DECEDENT'S NAME (First, Middle, Last)	Brow	N			MONTH	H DAY 7	YEAR 997	3. TIME OF DEATH					
	4. SOCIAL SECURITY NUMBER 5. SET 246 52 2191 1	6. AGE (In	43.4	UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS.	Month, Day, Yes		8. BIRTHI Country	PLACE (State or Foreign					
OR		*	HOSPIAL	CITY, TOWN	OR LOCATION OF GEAT	Н		UCS	ATH 6201625					
DIRECTOR	RESIDENCE OF DECEDENT  10e. STATE 10b. COUNTY		10c, CITY, T	OWN OR LOCAT	TON			T	10d. INSIDE CITY					
Dia .		rge's County	Fort	Washing	,				LIMITS?					
FUNERAL	10. STREET AND NUMBER 12707 Parkton Street			101	20744				tes of America					
B⊀	1 Never Married 2 Married FO	IS DECEDENT EVER IN U RCES? 1 - YES YES, GIVE WAR OR DATI	2 NO	If yes, sp	ENDENT OF HISPANIC ecity Cuben, Mexican, 2 XNO Specify:	ORIGIN? (Specifi Puerto Rican, atc.	y Yes or No—	14. RACE Black, Specify	- American Indian, White, etc.					
E I	15. DECEDENT'S EDUCATION (Specify only highest grade complete	ed)	6e. DECEDENT'S USE (Give kind of work life. Do NOT use re	JAL OCCUPATIO	ON st of working	16b. KIND OF	BUSINESS/IN	DUSTRY						
COMPLETED	Elementary/Secondary (0-12) College	ge (1-4 or 5+)	Domestic			Priva	ite Home	s						
CON	17. FATHER'S NAME (First, Middle, Lest)				18. MOTHER'S NAME									
BE	Oscar Strickland  19a. INFORMANT'S NAME (Type/Print)				Harriett									
5	Coy Cooper / Son				ve, Silver									
	20e. METHOD OF DISPOSITION 1		LACE AND DATE OF O ery, cremetory or other ickland Fam			6//4	LOCATION — opring H		orth Carolina					
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE #M00690  22. NAME AND ADDRESS OF FACILITY  William Toney's Funeral Home (P.O. Box 430)  516 Poplar Street, Spring Hope, North Carolina 2													
23. PART i. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or reepiretory arrest, shock, or heart failure. List only one ceuse on each line.  IMMEDIATE CAUSE (Finsi disease or condition resulting in death)  a. APTERIOSCUERDITC CAUTIONSCUERT  BUE TO (OR AS A CONSEQUENCE OF):														
CERTIFICATION	If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A C												
MEDICAL	PART II. Other significant conditions control	ibuting to deeth but	not reaulting in the	ne underlying	ceuse given in Pa	PER	S AN AUTOPSY FORMED? S 2 7 NO		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	PITAL:			ACE OF DEATH (Check	only one)								
IYSI	1 YES 2 図 NO 1 解 In	patient 2 - ER/Outpati			5 - Residence 6									
ВУ РН	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	RK? ES 2 NO	8d. DESCRIBE HO	W INJURY OC	CURED								
COMPLETED	29e. CERTIFIER (Check only one) 1 To CERTIFYING PHYSICIAN: To MEDICAL EXAMINER: On the								end manner ee stated.					
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER  30. NAME AND ADDRESS OF PERSON WHO COMP	TIED CAUSE OF DEAT	HUTEN 270 (See Oct		29c. LICENSE NUMBE D 1854	5	29d. DAT	SIGNED (	Month, Day, Year)					
	PHILIP WISETKU	1 MD.	700 €		INE CE	NER	WA		F Md.					
	31. DATE FILED (Month, Day, Year) 32  JUL 0 3 1997	. RECISTRAR'S SIGNATI	URE Pandelle	Texas					. 32					



State of Maryland / Department of Health and Mental Hygiene 97

						(	Cert	fificate of	Death			Reg. No.			
		ш	1. Decedent's Neme (First, Midd	fle, Last)							2. Dete of De		<b></b> C1	3. Time of I	Death
	Physici /Medic		Cecelia Jo Be	cker							June	28. 19	Year 997	7:18	am
4	Examir		4e. Fecility Neme (If not institution		ımber)				4b. City, To	wn, or L	ocation of Death			7.10	CIII
	Exami		Anne Arundel						Annar	ooli	e	Anno	Arun	1ab	
Н	Funeral		5. Social Security Numbar	6. Sex	7. Age (In yr	s. last birth	day)	If Under 1 Yaar	If Under						Foraign
ш	Director		442-24-1332	1 □ M 2 <b>E</b> (F	7			Months Days	Hours	Min.	8. Date of Bird (Month, De	y, Year) 9, 1925		place (Stete or htry)	, oralgi
			Usual Residence of Decedent								OCL.	7, 1723	OK		
	danc Manc		10a. State 10b. Count	У	10c. C	City, Town	or Loc	ation					1	0d. Inside City	y Limits
	Man	ō	MD Anne	Arunde1	A	rno1d								1 🗆 Yes	2 No
	the 28a	Director	10e. Street end Number					10f. Zip Code				10g. Citizen of N	Whet Cour	ntrv?	
	With the second	ō	808 Barrett A	7707110				·				-			
	s 23	Funeral	11. Marital Status		edent Evar In	11.6	12 M	21012	dispoplo Ori	ning (Sn	onifu Voc or No	USA	e - Amaric	an Indian	
	her d	ä		Armed Fo	orces?	0,3.	If.	as Decedent of I Yes, specify Cub	en, Mexicen	, Puerto	Rican, etc.)	Blac	ck, White,		
20	s aff	by F	1 ☐ Navar Married 2 ☐ Ma 3 🕱 Widowed 4 ☐ Divorce	If Yes, Gi	ive		1[	Yes 2 No	Specify:			Specify	w. Whi	te	
21215-0020	J within 72 hours after deeth with the Maryland ilena. Than "natural", or Items 23a or 28a-f show the Wadcal Examiner must be notified at	D			Detes:	10- 5		- N- 11 1 O			1	400 161 1 16	1		
5	c * 2	Completed	(Specify only high	nt's Education est grade completed)		160. L	Give k	nt's Usuel Occu ind of work done O NOT use retire	during mos	t of work	ing	16b. Kind of B	JSINESS/Inc	Justry	
12	e filed within at Hygiena. other than vent, the we	ם	Elementary/Secondary (0-12)	Cotlege (	1-4or 5+)	,			0)						
2	Hygie her nt,		12 17. Father's Name (First, Middle	I get)			_Ho	memaker	10 Moths	e'e Nam	o /First Middle	Maiden Sumen			
an	be de la la la la la la la la la la la la la	Be		,									la)		
Ž	should by nd Menta marked umatic ev	10	Willie Hooper								Circhof				
Maryland	2 2 2		19a. Informent's Name/Relation				_	Address (Stree						Code)	
	Haalth tem 27 le		Donald E. Bec	ker	The same	_		Barrett	Avenu	ie, A					
9	of H		20e. Method of Disposition 1 ■ Burial 2 □ Cremation	3 □Removel from		cematery,	creme	tion (Neme of etory or other pla	ce)	i.	July 2,	20c. Location -	City or To	wn, State	
E	Pag ment: ant: ury		4 ☐ Donation 5 ☐ Other (			aryla	nd	Veteran	's Cem		1997	Crowns	vill	e, MD	
Baltimore,	permit. Pages 1 and Department of Haalth Important: If Item 27 any Injury or other tones.		21. Signature of Funeral Service	Liberisee	1	7		Name and Addre		*					
$\mathbf{\omega}$	8 9 E 5 8		Bullet	_	//			Barrance 495 Rite	o & So	ns,	P.A. Se	everna E	ark	Funera:	1 Hom
	_		23a. Part1. Enter tha disease, or shock, or heart failure. Lis	r complications thet	ceusad pe de	ath. Do no	t enter	tha moda of dyi	ng, such as	cardiac	or respiratory a	rrest,	MD Z	Approximata	
	Physician		shock, or heart failure. Lis	t only one ceuse on e	ech line.								ì	Interval Betw Onsat and De	reen aath
	/Medical		Immadiata Ceuse (Final	Δ-	14			/	1		1.1	6.1	4	21.	
	Examiner		disease or condition resulting in death)	e. / C	ure.	inte	ri	or wall	myo	can	2141 /1	n parcer	dh	2 401	urs
ш		je l			Due to	(or es e co	nsegu	ence of):						1.6.	
	utad d ansit	Examiner	Commentation that the state of	b. Cor		(or es e co			040515					MKNO	iwn
ć	axec n an ial-tr	Exa	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury		D0040	(OI es e CO	nsequ	ence oi).					I		
)9/	e be sicia e bur	Ca	Ceuse (Disease or injury that initiated avents	С.	Due to	(0.000000	200011	2000 06):							
68760,	certificete be axecuted ding physician and isa as the burial-transit	edicai	rasulting In deeth) Lest		Dualo	(or as a co	iseque	ence or):					+		
X	- 63	₹		d											
ğ	atte	Physician	D-411 Other 1-17												
P.O.	thet tha de ed by the detached	ys	Pert II. Other significant conditi							•		tobacco use co		. /	1
	ras thet thigned by		Chronic ob	structive	e puli	mona	ry	disons	· R_		10	Yes 2□ No	3 ☐ Prol	bably 4	Jnknown \
ds	sign d be	d by	Chronic ob Fever du	1	1 11						240 Was	en eutopsy	24h W.	ere eutopsy fir	ndinas
9	v require been si should	Completed	rever du	e to pro	bable	. 501	251	5				rmed?	ava	ailable prior to mpletion of ca	)
ec	2 00 01	npl										4		death?	
=	The see	S									101	Yas 2 No	1 [	☐Yes 2☐ N	No
of Vital Records,	Physician: The this certificate ral director, peg	Be	25. Wes cese referred to medical exeminer?							of Deet	h (Check only c	one)			
Ę	S o D	ဥ	1 ☐ Yes 2 No	Hospital:	Inpatient	ER/Outp	atient	3□ DOA Ot	her: 4 Nu	irsing Ho	me 5 Resid	dence 6 □Oth	er (Specif	y)	
ם	Jing Ph h. After th funeral	ü	27. Manner of Death  1 ■ Naturat 5 □ Pendi	28a. Date (Mon	of Injury th, Day Yeer)	28b. Tin		28c. Inju Wo	ry et rk?		28d. Describe I	how injury occur	red		
.00	Attending Ph or daath. octor: Atter thi by the funeral	ati	2 ☐ Accident invest	igation					Yes 2□	No					
Division	or Attend after daath Director: / d in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	nined 286. Place	of Injury - At ling, etc. (Spec	home, farm	n, stree	et, factory, office			28f. Location (S City or Tox	Street and Numb vn, State)	er or Rura	I Route Numb	)e <i>r</i> ,
	tal or rs afte al Olr led in	Cer			g, (-p	,,					,				
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 Certifyi	ng Phyeician: To the	best of my kn	owledge, o	leath o	occurred et the ti	me, date en	d plece,	end due to the	cause(s) end me	enner es si	teted.	
	he H in 24 he Fi	edical	one)	Examiner: On the band man	ner stated.	lettori eriozi	or inve	stigation, in my o	opinion, deal	tn occur	ed et the time,	date end place,	end due to	) the ceuse(s)	
	With to the control	Σ	29b. Signatura and title of certific	m 4 4 1	1			29c. Licans	sa number			29d. Date signe	d (Month,	Dey, Yeer)	
			(w/m/s	WK	14-20 -			00	592	-8		June:	18	1997	7
			30. Name end eddrass of person	who completed caus	se of deeth (Its	em 23e) (Tr	vpe. P	rint)	- /-			urie	1	111	
			Charles W.	Lima	MD	200	72	Madie	(Pu	1111	HI 00 1	tunap	0/12	MDZ	1401
	Sta	te	31. Data filed (Month, Day, Yaar,	32. R	Registrar's Sign	nature	7	TAIRCHE	4_1_K	MA	7100,	THE	1113/	1117	1 101
	Registr		1111 00	1007	legistrar's Sign	>	D_0	02-							
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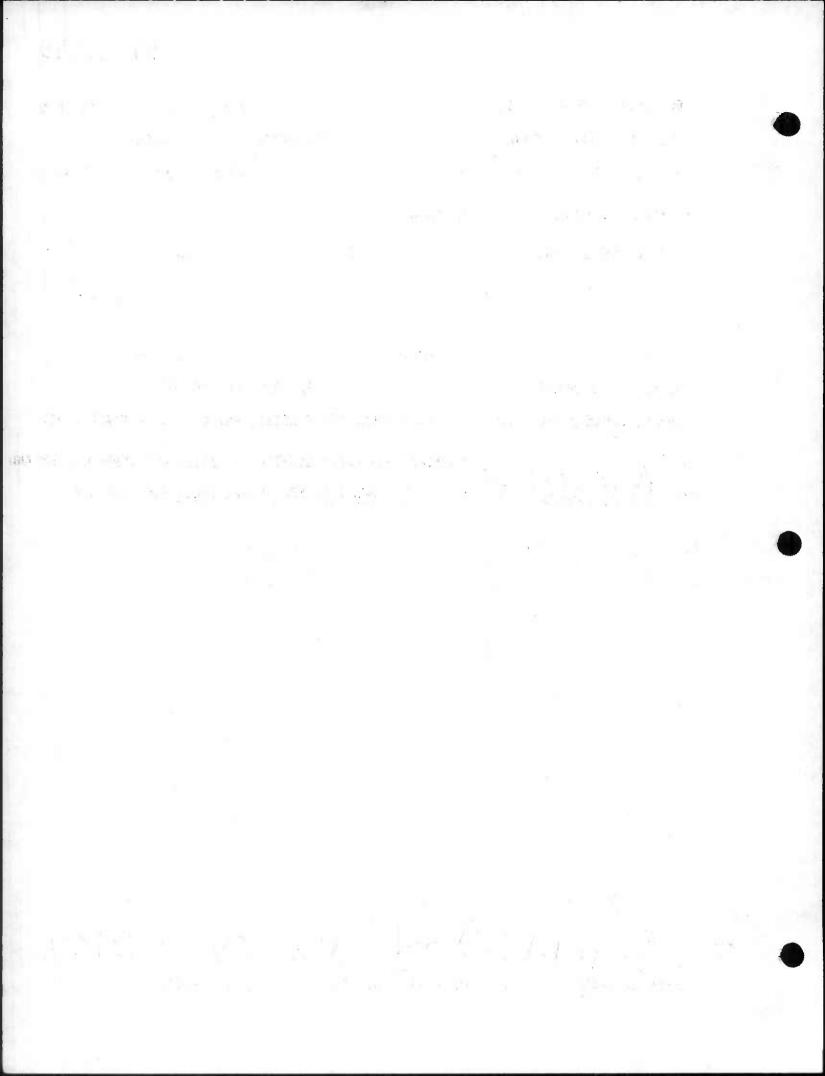
						Certificate		a worker rry	Reg. No.	1 6	.1240		
	Physic	ian	Decedent's Neme (First, Middle, Landson Company)					2. Dete of De Month	eath Dey	Yeer	3. Time of Death		
	/Medi		Pauline W.			Burke Ju				1001	12:23 PM		
	Exami	ner	4e. Fecility Neme (If not institution, give street end number)			4b. City, Town, or Location of De			h 4c. County	of Death			
L			4187 Solomons Is				Harwo		Anne	Arund	el		
	Funeral Director	ľ		Sex 7. Age 1□ M 2DXF 85	(In yrs. lest bir			frs. 8. Date of Bir (Month, De July 11		9. Birthpla Count Ohi	ace (State or Foreign try)		
	P .		Usuel Residence of Decedent					Duly 11	9 1/11	OIII	0		
	aryler show		10e. Stete 10b. County		n or Location				10	Od. Inside City Limits			
	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Meryland Depertment of Health end Mental Hygiene. Important: if Itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ances.	cto	Maryland Anne Arundel			Harwood				1∭ Yes 2□N			
		Funeral Director	10e. Street end Number			10f. Zip Code			10g. Citizen of Whet Country?				
		rai	4187 Solomons Is				20776			USA			
	them free	Ë	11. Marital Status	12. Wes Decedent E Armed Forces?		If Yes, specif	nt of Hispanic Origin? Cuben, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	Bled	e - America ck, White, e			
020	urs aff	by F	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	1 ☐ Yes XX No If Yes, Give Yeer or Dates:	0	1 ☐ Yes 2 [	No Specify:		Specify	". Wh	ite		
Baltimore, Maryland 21215-0020	2 hou	ted	15. Decedent's E	ducation	16e.	Decedent's Usue!	Occupation		16b. Kind of Bu				
	thin 7	npie	(Specify only highest gra Elementary/Secondery (0-12)	College (1-4or 5+	-)	lite. DO NOT use	done during most of v retired)	working					
	od w Sgien t, th	To Be Completed	12th		·	ministra	ive Assis	tant	Dep't.	of J	ustice		
	d off		17. Fether's Neme (First, Middle, Last				18. Mother's N	Neme (First, Middle,					
	Should be filed with end Mental Hygiene. Is marked other than aumatic event, the Mannetic		Wilbur Wil	0, 3				. Alspac					
	12 sh h end r is m		19e. Informant's Name/Relationship ( Lynn W. Headley/				Street end Number or						
	1 end Health am 27		20e. Method of Disposition	Niece		O Bancro		olonial E					
	Peges nent of I int: if its		1XXBurial 2 ☐ Cremetion 3 ☐	Removal from State		b. Place of Disposition (Neme of cemetery, cremetory or other place)		1		c. Location - City or Town, State			
	ortani		4 Donetion 5 Other (Specify)  21. Signature of Funeral Service Licensee			nkemont Mem'l. Gardens 7-7-97 Davidsonville, Marylan							
	permit. Pege Depertment of Important: if any injury or ance.		· Illuttila		22. Name end Address of Fecility George P. Kalas Funeral Home								
	_		2973 Solomons Island Rd. Edgewater, Md. 210										
	Physician		shock, or heart feilure. List only	one cause on each line	).	lot enter the mode	or dying, such es card	ilac or respiretory e	rrest,	1	Approximete Intervel Between Onset end Death		
	/Medical		Immediate Cause (Finel	2000	OLHONA	all Ar	REST		1				
1	Examiner	ш	Immediate Cause (Finel disease or condition resulting in deeth)  e. CARDIO PULM ARREST  Due to (or es e consequence of):						-				
Ц	n #	Examiner		GA	1 Blut	DER C	L.			1			
	The law requires that the death certificete be executed at hes been signed by the ettending physicien and page 2 should be deteched for use as the buriet-transit		Sequentially list conditions,		or es e consequence of):								
68760,	oe exe	9	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury	N					i				
87	cete b	dica	thet initieted events resulting in deeth) Lest		Due to (or es e consequence of):					-			
	ding l	Physician/Medical		d. CHF									
Вох	that the death certined by the ettending deteched for use e	ciar											
P.O.	the d y the ached	hysi	Part II. Other eignificant conditions contributing to death but not resulti						Old tobacco use contribute to the cause of death?				
	es that igned b	by P	ATRIAL T	$\sim$				Tes 20 No 30 Probably 42 Officiown					
Records,	v requires been sig should b		ATRIAL FI	SUM	NOME			24a. Wes	en eutopsy	contribute to the cause of death?  Ito 3 Probably 4 Unknown  24b. Were eutopsy findings evailable prior to completion of cause of death?			
900	aw re s bee	Completed	OOKVIZ	3-1/				– pend	rmed?	com	npletion of cause		
Ä	The law							10	Yes 25 No	10	lYes 2□ No		
of Vital		Be	25. Wes case referred to medical exeminer?				26. Place of D	Deeth (Check only o	one)				
¥ V		2	1 Yes 2 No	Hospital: 1 ☐ Inpatien	2 1 ER/Ou	patient 3 DOA	Other: 4 Nursing	Home 5 Resid	dence 6 Oth	er (Specify)	)		
	m 6 9	ii o	27. Menney of Deeth 1 ☐Naturel 5 ☐ Pending   28a. Dete of Injury (Month, Dey Year)   28b. Time of Injury et Work?   28c. Injury et Work?					28d. Describe I	28d. Describe how injury occurred				
Sio	Attending or deeth.	cati	2 Accident investigation 3 Suicide 6 Could not be										
Division	or At offer of Direct in by	Certification:	determined 266. Piece of injury. At nome, ferm, street, fectory, office 26f. Loca						ation (Street and Number or Rural Route Number, or Town, Stete)				
	To the Hospital or Attending within 24 hours efter deeth.  To the Funeral Director: After completely filled in by the fun	ပို	29a. Certifier 1 Certifying Physician: To the best of my knowledge deeth occurred at the time date and place and due to the cause(s) and manner as stated										
	Hos 24 h Fun etely	Medicai	29a. Certifier  (Check only one)  1. Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, dele end place, end due to the ceuse(s) end menner es steted.  2. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and menner steled.										
	ro the		29b. Signeture and title of certifier 29d. Date signed (Mont						d (Month, D	Day, Year)			
	F 2 F 0		1 20050741 7/2/97						197	W			
		1	30. Neme end address of person who	completed cause of der	ith (Itom 2)a) (	Time Drint)							
_			Exic A.S	scotted, XX	139	DUD S	cotours 1.	SL. KD/d	mustos	ころとい	21401		
	Sta		31. Dete filed (Month, Day, Year)	32. Registrar									
	Registr		JUL 071	997 Popul	a Davidson	- Randell							
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 2 1 2 4 9

	Certificate	of Death	Re	eg. No.					
Physician	Decedent's Name (First, Middle, Last)		2. Dete of Deet Month	h Dey Ye	3. Time of Death				
/Medical	FLORENCE ROSE BEDINGFIELD		JULY 1,	1997	11:15 AM				
Examiner	4e. Fecility Neme (If not institution, give street end number)  5537 HUCKLEBERRY DRIVE	4b. City, Town, or L BRYANTOWN		4c. County of D					
Funeral	5. Social Security Number 6. Sex 7. Age (In vrs. lest birthday) If Under 1								
Director	578-05-8766 1□ M 2 N F 84 Yrs. Months D Usuel Residence of Decedent	Days Hours Min.	8. Date of Birth (Month, Dey, MARCH 3	, 1913	Birthplace (State or Foreig Country) PENNSYLVANIA				
titled at	10a. Stete 10b. County 10c. City, Town or Locetion BRYANTOWN				10d. Inside City Limits 1 ☐ Yes 2 📉 No				
ritems 23a or 28a-fs rites: mast be notified Funeral Director	10e. Street end Number         10f. Zip Cd           7064 OLD LEONARDTOWN ROAD         2061	10f. Zip Code <b>20617</b>			10g. Citizen of Whet Country?				
by St.	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Yeer or Dates:	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.)     □ Yes 2 No Specify:			or No- 14. Race - American Indien, Bleck, White, etc. Specify: WHITE				
ygiene. Nor than "natural", North Medical Exa Completed by	15. Decedent's Education (Specify only highest grede completed)  Elementery/Secondery (0-12)  College (1-4or 5+)	done during most of work	king	16b. Kind of Busine					
Per t	12 HOMEMAKER  17. Fether's Name (First, Middle, Last)	4D Matheda Mari	o /Final Adiatalia A	OWN HOM	Ε				
marked other matic event, To Be C	DANIEL HAROLD BURKE	75 - 345	e (First, Middle, N E ELEANO						
	19e. Informent's Neme/Reletionship (Type, Print)  19b. Mailing Address (S				e, Zip Code)				
# CV =	JOAN B. CROWN / DAUGHTER 5537 HUCKLE								
	20a. Method of Disposition (Name cemetery, cremetory or other	of or place)	Dete 2	20c. Location - City	or Town, State				
7 2	1 Burial 2 oremation 3 Removal from Stete 4 Donation 5 Other (Specify)  MARYLAND VETERA		V 7/7/10	07 CHELT	ENHAM, MARYL				
in in	6/1/0	Address of Fecility	1 //// 13	37 GILLI	LINIANI, PAKI				
Important: If It any injury or conce.	THE HUNT	T FUNERAL H	OME INC	PO	ROY 156				
1000	WALDORF	MARYL AND	20604-01	56	DON 130,				
	23a. Per11. Enter the disease, or complications that ceused the deeth. Do not enter the mode of shock, or heert feilure. List only one cause on each line.	f dying, such es cardiac	or respiretory erre	st,	Approximete Intervel Between				
ysician	$\Lambda$ $\Lambda$ $\Lambda$	1	0		Onset end Death				
ledical	Immediate Ceuse (Final	1 1 120	Cre X h	me !	x Mon				
aminer	disease or condition resulting in death)	1							
e e	Due to (or es e consequence of):	couly	"las-	1.),	XZMins				
ial-transit Examine	p/Actionacc. V4		1	-					
burlal-tran	Sequentially list conditions, if eny, leading to immediate	0 1	1	100	3				
	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury								
s the bu	thet initiated events resulting in deeth) Lest								
S S									
C 3   E									
d by the detached	Pert II. Other significant conditions contributing to death but not resulting in the underlying ceus	e given in Pert I.	23b. Did tobacco use contribute to the cause of a 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Ur						
should			24e. Wes en		b. Were eutopsy findings eveileble prior to completion of cause of deeth?				
page 2			1 ☐ Ye	s ale No	1 ☐ Yes 2 ☐ No				
rector, pa	25. Was cese referred to medical	26 Place of Deet			10165 20160				
	exeminer? Hospitel:	Other	h (Check only one						
		4 □ Nursing Ho	28d. Describe ho	nce 6 Other (S	pecity)				
After fune flon:	1 Naturel 5 Pending (Month, Dey Year) Injury	Work?	Low. Describe 110	a aguly occurred					
tor:	3 Suicide 6 Could not be	1 Yes 2 No	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)						
al Director: After ted in by the funer contification:	determined  28e. Plece of Injury - At home, ferm, street, factory, of building, etc. (Specify)	fice							
O Bed									
To the Funeral Director: completely filled in by the Medical Certifica	Certifying Physician: To the best of my knowledge, deeth occurred et the Medical Examiner: On the basis of exemination end/or investigation, in	ne time, dete end place, my opinion, deeth occurr	end due to the cered et the time. de	use(s) end menner	es steted.				
Med Med	end menner stated.								
200	29b. Signature and title of certifier	cense number	29	d. Date signed (Mo	onth, Day, Yeer)				
	I per Volatel seal	1)200	201	1	3 97				
	30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)	0	2 - 1.	-	- 1 1 1.				
	GEORGE H. WATNEN, MD, 11345 PEMBROOKE SQ. #1	03, WALDORE	MD 20	0603					
State	31. Date filed (Month, Day, 1847) 32. Registrer's Signature	_ ,	,						
Registrar	JUL 0 3 1997 Julia Stavelson Rarball								



### PI

				nk. Assure		-			
	State of Maryla			of Death	,	giene 3 Reg. No.	7 21250		
Decedent's Name (First, Middle, Las SHIRLEY	st) MAXINE	В	ANEY		2. Date of Dea	o, Day 1997	Year 9:45 PM		
Facility Name (If not institution, give	G CENTER			LEONARD	· OHH	4c. County			
Social Security Number 6. S 05-12-9256 1 sual Residence of Decedent	ex ☐ M 2 A F 7. Age (In yrs	2 Yrs.	Months D		Ars. 8. Date of Birtl (Month, Day AUGUST	/, Year)	Birthplace (State or Foreign Country)     PENNSYLVANIA		
a. State 10b. County ST. MAR		ECHANIC					10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
e. Street and Number 19831 SKY VIEW DR	IVE		10f. Zip Co	20659		10g. Citizen of	What Country?		
Marital Status  1 □ Never Married 2 □ Married  3 ♥ Widowed 4 □ Divorced	12. Was Decadent Ever in Armed Forces?  1 ☐ Yes 2 🐧 No If Yes, Give Year or Dates:	if	as Decedent Yes, specify	t of Hispanic Origin? Cuban, Mexican, Pu No Specify:	(Specify Yes or No-	14. Rac	ce - American Indian, ck, White, etc. by: WHITE		
15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	(Give k	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  HOUSEWIFE				16b. Kind of Business/Industry			
Father's Name (First, Middle, Last)  LARENCE BRADY, S	R.	11003	18. Mother's Name (First, Middle, Maide BERTHA PIERCE				OWN HOME en Surname)		
ua. Informant's Neme/Relationship (7)				treet and Number or			, State, Zip Code) MD 20659		
MARK G BROHAM  Ba. Part1. Enter the disease, or companion, or heert failure. List only of	MO005	3 P.C	BOX :	ddress of Facility T FUNERAL 156, WALD( f dying, such es card	ORF, MARYI	AND 2	Approximete Interval Between Onset end Death		
mediate Ceuse (Final lease or condition sulting in death)	a chronic obstructive pulmonary disease						Ten years		
	b. Lung	or es a consequ		·			about three		
quentially list conditions, ny, leading to immediate ise. Enter Underlying use (Disease or Injury	Due to (or es e consequence of):						25017		
at initiated events sulting in death) Last	Due to (or as a consequenca of):								
t II. Other significant conditions co	entributing to death but not re	sulting In the und	lerlying caus	e given in Part I.	23b. Did to		ontribute to the cause of death?		
					24a. Was e perfor	en eutopsy med?	24b. Were autopsy findings eveileble prior to completion of cause of death?		
Was case referred to medical					1 🗆 Y		1 ☐ Yes 2 ☐ No		
examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ED/Outpotion	2□ №	Other:	eath (Check only or		on (Conside)		
Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ Survival Nursing Home 5 ☐ Residence 6 ☐ Other (Specific Month, Day Year) ☐ 28b. Time of Injury Month, Day Year) ☐ 28c. Injury at Work? ☐ 1 ☐ Yes 2 ☒ No								
1 Natural 5 ☐ Pending 2 ☐ Accident investigation			IVI	1 185 ZUAINO					

29c. License number

D50044

29d. Date signed (Month, Day, Year)

JULY 1, 1997

20650

permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, The Medical Examiner must be notified at once. Baltimore, Maryland 21215-0020 JPK **Physician** /Medical

Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

Director

Funeral

Completed by

To Be

29b. Signature end title of certified

Physician/Medical Examiner To the Hospital or Attending Physician: The law requires thet the deeth certificate be executed within 24 hours after daeth.

To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be deteched for use as the burish-transit Division of Vital Records, P.O. Box 68760, Be Completed by Medical Certification: To

> State Registrar

31. Date filed (Month, Day, Year)

JUL 0 3

MOHAMMAD ANISURM RAHMAN, M.D., 24035 THREE NOTCH RD. (RT.235), LEONARDTOWN, MD 32. Registrer's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (P.O.BOX 664)

DR.M.A. Rahnay, us)

No. 2 Act 1112 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Clifton Jerome Broadwater 29,1997 5:00 A.M. June /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Lonaconing Egle Nursing Home Allegany If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Plant Country Mary 26, 1911 Mary 1 and 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1√2 M 2□ F 217-10-4768 86 Yrs. Director Usuel Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haelih and Mental Hyglena. Important: if Item 27 is marked other than "netural", or itema 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Allegany Lonaconing 1 Yes 2 No Completed by Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3 Dudley Street 21539 USA 12. Wes Decedent Ever In U,S. Armed Forces? 13. Wes Decedent of Hispenic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American Indien, Bleck, White, etc. 1⊠Yes 2□No If Yes, Give WW I I Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√2 No Specify: SpecifiWhite 3 ₩ Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Spinning Dept. 12 Labor 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Nelson Broadwater Virginia Broadwater 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Sandra D. Grandstaff 39 E. Railroad St.,Lonaconing,Md. 21539 20b. Pleca of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete July2, 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State Laurel Hill Cemetery 4 Donetion 5 Dother (Specify) Moscow Mills, Md. 1997 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Eichhorn-McKenzie Funeral Home ans E. 23a. Part1/Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one ceuse on eech line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) Hear Examiner Due to (or es e consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death cartificate be associated within 64 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be datached for use as the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Last Due to (or es e consequença of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequenca of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 € Unknown Be Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 28. Place of Deeth (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of 28c. injury et Work? 28a. Dete of Injury (Month, Dev Year) Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stefe) 3 Sulcide 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, and due to the cause(s) end manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signeture end title of cartifier 29c. License number 00100-60 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) JACKSON ST. LONACONING

State Registrar WILES JR.

M.D.

51 32 Registrats Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** Month Adolph E. Buescher, Jr. July 1997 6:30 am /Medical 4a. Facility Name (If not Institution, give straat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14 Papermill Street Easton Talbot If Under 1 Year if Under 24 Hrs. 8. Dete of Birth
Month, Days Hours Min. (Month, Day, Year) 5. Social Sacurity Number Birthpleca (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 1⊠M 2□ F Director Yrs 498-12-7356 74 Oct.6,1922 Missouri Usuei Residence of Dacedant with the Maryland 10a State 10b. County 10c. City, Town or Location 7 le marked other than "naturel", or items 23a or 28a-f show treumstic event, the Madical Examination must be notified at 10d, Inside City Limits tyZ Yes 2 □ No Director Talbot Easton Maryland 10a. Street end Number 10f. Zip Code 10g. Citizen of What Country? 14 Papermill Street USA death 21601 Funeral 12. Was Decedent Evar In U,S. Armed Forces? 13. Wes Decedent of Hispenic Orlgin? (Specify Yas or No-it Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - American indien, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer d Depertment of Heelih end Mentel Hyglene. Important: If item 27 ie marked other then "natural" any injury or other treumatic events in the process of the p 1 Nevar Married 2 Married 1 ∑Yas 2 ☐ No it Yes, Give Year or Detes: 1 ☐ Yes 2 No Specify: b Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Dacadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 18b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Missile & Space 12 5+ 17. Fether's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Malden Surneme) Adolph E. Buescher, Sr. Eugenie Stroh 19e. informant's Neme/Raletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ruth L. Buescher/Wife 14 Papermill Street, Easton, MD 21601 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Ramoval from Stete 4 Donetion 5 Other (Specify) 7/5 Oxford Cemetery Oxford, MD 21654 21. Signature of Funaral Servica Licansee 22. Name and Address of Fecility Fellows, Helfenbein & Newnam Funeral Home NHOL MERCERON CFSP 200 S. Harrison St., Easton, MD Z. 23a. Pert1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heef tellure. List only one cause on each line. Approximata intervel Between Onset end Death **Physician** immediate Cause (Final disease or condition resulting in deeth) /Medical Adenocarcinoma of the esophagus, metastatic 3 years Examiner Due to (or es e consequence ot): Examiner physician end the burial-transit or Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or es e consequance of): esn P.O. signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part i. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably Unknown Records, δ been si 24b. Were eutopsy findings eveilebla prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? page 2 1 ☐ Yes 2 X No 1 ☐ Yes 2 No Division of Vital director. Be 25. Wes case reterred to medical 26. Piace of Deeth (Check only one) examiner? 1X Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA After this funeral 27. Menner of Death 28e. Date of injury (Month, Dev Year) 28b. Time of 28d, Describe how injury occurred 28c. injury et Work? 1 Naturel 5 Pending investigation deeth. 1 ☐ Yes 2 ☐ No a Funeral Director: A Florest of Funeral Director: A pletely filled in by the fi 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of injury - At home, ferm, street, tectory, office building, etc. (Specify) 4 Homicide Hospital To the Hospi within 24 hou To the Funer completely fil 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end pieca, and due to the ceuse(s) end menner as stated. Medical (Check only one) Medical Examiner: On the basis of axamination and/or investigetion, in my opinion, death occurred at the time, date and piece, and due to the ceusa(s) and menner steted. 29b. Signature and title of certifier 29c. Licanse number 29d. Dete signed (Month, Day, Year) D06804 July, 2, 1997 30. Name end eddress of person who complated cause of deeth (Item 23a) (Type, Print) Memorial Hosp. 219 S. Washington St., Easton, MD 21601

State Registrar

Stout, M.D.

32. Registrar's Signature

a-Randese

David A. 31. Date tiled (Month, Dey, Year)

JUL

97-3438-047 B.K.S Co

Examiner

Physician/Medical

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Completed

Be

2

Certification:

Medical

Baltimore, Maryland 21215-0020

Physician /Medical

Examiner

physician and s the burial-transit

88 the attanding usa jo

been signed by the a should be detached t

certificate

funeral director,

completely filled in by

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified

The law requires that the death certificate be axecuted

Division of Vital Records, P.O. Box 68760,

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

ISULA R Number 3864 of Decedent 10b. County d Worce Number Cedar St	ster  12. Wes Decedant Armad Forces [and I ] Yas 2	EDICAI pa (In yrs. last  10c. City, T  POCOI	Yrs.  Town or Location	City 10f. Zip Cod 21851	SALI ar If Under 2 ys Hours	SBU	8. Data of Birth (Month Day 01-17-5	4c. County WIC(	9. Birthpla Country Maryla	ca (State or Foreign v) and d. Insida City Limits 12 Yas 2 □ No		
ISULA R Number 3864 of Decedent 10b. County d Worce Number Cedar St	EGIONAL ME 6. Sax 7. Ag 1 M 2 F 3  ster  reet 12. Wes Decedant Armad Forcas 3 iad 1 M 2 S = 2	EDICAI pa (In yrs. last  10c. City, T  POCOI	Yrs.  Town or Location	ti Undar 1 Ya Months Day eation  City  10f. Zip Cod 21851	SALI ar If Under 2 ys Hours	SBU 24 Hrs.	DRY  8. Data of Birth (Month Day 01-17-5	4c. County WICC	of Daafh OMICO 9. Birthpla Country Maryla	ca (State or Foreign  Ind  I. Insida City Limits  1. Yas 2 □ No		
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arried 2 Marri	Armad Forcas?		13. V	Ina Danadani	VII OCCUT DELEGE							
1 Navar Married 2 Marriad 1 Yas 2 No							Hispanic Origin? (Specify Yes or No- an, Maxican, Puarto Rican, atc.)  Specify:  14. Race - Amarican Indian, Black, White, afc.  Specify:  Black					
15. Decedant	t's Educetion	1	6a. Deced	ant's Usual Oc	cupation	of worki	16h Kind of Business					
condary (0-12)	College (1-4or 5	5+)	life. D	O NOT use ret	ne during most ired)	OI WOIN	vorking					
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a (First, Middle, L	Last)				18. Mofhar	's Nama	(First, Middle, I	<i>Maiden Sum</i> am	ne)			
us Butle	r				Poi	inse	ttia De	ennis				
2 Cremation		ceme	etery, crem	atory or other p	olace)	6	-		1			
S	us Butle s Name/Ralationsl ettia Der Disposition 2 Cremation on 5 Other (S)	Disposition	us Butler s Name/Ralationship (Type, Print) ettia Dennis (mother)  Disposition 2 Cremation 3 Ramoval from State on 5 Other (Specify)	us Butler s Name/Ralationship (Type, Print) ettia Dennis (mother)  Disposition 2 Cremation 3 Ramoval from State on 5 Other (Specify)  19b. Mailing 612 C	The (First, Middle, Last)  LUS BUTLET  S Name/Ralationship (Type, Print)  LUS BUTLET  S Name/Ralationship (Type, Print)  LUS Dennis (mother)  Disposition  2 Cremation 3 Ramoval from State on 5 Other (Specify)  2 Cottage Grove Center (Specify)	The (First, Middle, Last)  LUS Butler  S Name/Ralationship (Type, Print)  Ettia Dennis (mother)  Disposition  2 Cremation 3 Ramoval from State on 5 Other (Specify)  18. Mofhai  Position  19b. Mailing Addrass (Street and Number 612 Cedar Street, I	The (First, Middle, Last)  LUS BUTLET  S Name/Ralationship (Type, Print)  Ettia Dennis (mother)  Disposition  2 Cremation 3 Ramoval from State on 5 Other (Specify)  18. Mofhar's Name  Poinse  19b. Mailing Addrass (Street and Number or Rura 612 Cedar Street, Poco  Cometery, crematory or other place)  Cottage Grove Cemetery  6	The (First, Middle, Last)  LUS BUTLET  S Name/Ralationship (Type, Print)  Ettia Dennis (mother)  Disposition  2 Cremation 3 Ramoval from State on 5 Other (Specify)  18. Mofhar's Nama (First, Middle, Median Poinsettia Densettia	The (First, Middle, Last)  LUS BUTLET  Poinsettia Dennis  State Dennis (mother)  18. Mofhar's Nama (First, Middle, Maiden Surman  Poinsettia Dennis  19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, 612 Cedar Street, Pocomoke City, Mar  20b. Place of Disposition 2 Cremation 3 Ramoval from State on 5 Othar (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Cottage Grove Cemetery 6/28/97 Pocomoke	The (First, Middle, Last)  18. Mofhar's Nama (First, Middle, Maiden Surmame)  Poinsettia Dennis  S Name/Ralationship (Type, Print)  ttia Dennis (mother)  19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Control of the Street, Pocomoke City, Maryland  2 Cedar Street, Pocomoke City, Maryland  20c. Location - City or Town cometery, crematory or other place)  Cottage Grove Cemetery  18. Mofhar's Nama (First, Middle, Maiden Surmame)  Poinsettia Dennis  2 Dennis  20c. Location - City or Town cometery, crematory or other place)  Cottage Grove Cemetery  18. Mofhar's Nama (First, Middle, Maiden Surmame)  Poinsettia Dennis  20c. Location - City or Town cometery, crematory or other place)		

atura of Funaral Sarvice Licensee

Bennie Smith Funeral Home

Po Box 1687, Easton, Maryland 21601 or heart failure. List only one cause on each line.

Immediata Causa (Final disaasa or condition resulting in deeth)

Due to (of as a consequence of):

Dua to (or as a consequence of):

Dua to (or es e consaquance of)

Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disease or Injury that initiated avants rasulting in death) Last

Part II. Other aignificant conditions of	ontributing to death	but not rasulting	o in the underlying	na ceuse aiven in	Pert I.

23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings evailabla prior fo complation of cause of death?

Approximata Interval Betw Onsat and Death

1 Yes 2 🗆 No

26. Placa of Daath (Check only one)

1 Yas 2 No

25.	Was cesa rafarrad to medical exeminar?
	1 ☐ Yas 2 ☐ No
27.	Mannar of Deeth

28e. Date of Injury (Month, Day Year) 5 Panding invastigation 6/22/97

28b. Tima of Injury 1237

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatiant 2 ER/Outpatianf 3 DOA 28c. Injury at Work? 1 ☐ Yes 2 No

28d. Describe how Injury occurred

pedestrian Struck by car

4 Homicide 29a. Cartifier

1 Natural

2 Accident

3 Suicide

28a. Place of Injury - Af homa, farm, fireat, factory, office

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

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28f. Locatio 29c. Licansa number 29d. Data signed (Month, Day, Year)

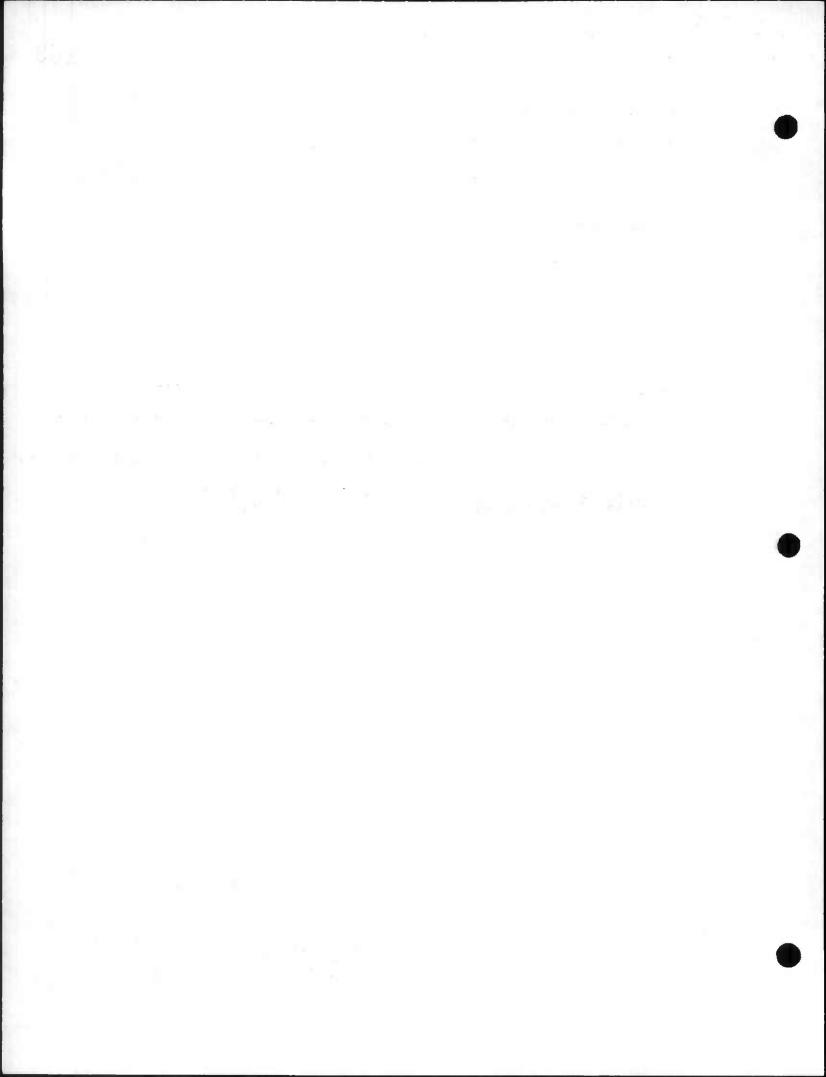
29b. Signatura and fitla of certifier 140

30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print) Dennis

HD 31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura

JUN 3 0 1997

State Registrar



# 219-07-0366 Baltimore, Maryland 21215-0020 WILLIAM BELL

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink

		S	tate of Maryla	ind / De	partment of F	lealth and M	ental Hyg		7 21254
Physici /Medic Examir	cal	Decedant's Name (First, Middla, Last)     WILLIAM      4a. Facility Name (If not institution, give street     PENINSULA REGIONAL	et and number)	ELL		4b. City, Town, or Lo	2. Date of Dea Month JUNE.	Day 23, 199	
Funeral Director		5. Social Security Number 219-07-0366 6. Sex 1√2 M	2□ F 7. Aga (In yr. 78	V	Months Davs	if Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day 3-21-	Year) 1919	9. Birthplace (Stata or Foraign Country) MARIUN ST. MD.
Maryland -f show	tor	Usual Residence of Decedent		City, Town or				41	10d. Inside City Limits
efter death with the Marylan or Nems 23s or 28s-f show miner must be nothed at	ai Director	10e. Street and Number 1525 ESQUIRE	DRIVE		10f. Zip Code 2180	D1	1	0g. Citizen of W	hat Country?
ours efter deal	by Funeral		Vas Decedent Ever in Armed Forces? Pes 2 No f Yas, Giva Year or Dates:	U,S. 1	3. Was Decedent of H If Yes, specify Cubs 1 ☐ Yes 2 ☐ No	llspanic Origin? (Span, Mexican, Puerto Specify:	ecity Yas or No- Rican, etc.)	Biack	- American Indian, , White, etc. AFRO-AMERICAN
permit. Pages 1 and 2 should be filled within 72 hours efter death with the Maryland Depertment of Heath and Mental Hygiene. Important: if flem 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic svent, the Medical Examinal must be nothed an once.	Completed	9th	n n <i>pleted)</i> College (1-4or 5+)		cedent's Usual Occup ive kind of work done e. DO NOT use retired	ation during most of work i)	ing	RET. CU	iness/Industry
hould be fill d Mental Hy marked oth matic sven	To Be	17. Fathar's Nama (First, Middla, Last)  FRANK BOR  19a. tnformant's Name/Relationship (Type, I	DEN	10b M	nilina Addrana /Street	18. Mother's Name	MARY	EMILY E	BELL
t end 2 s Health en tem 27 is r other traus		NORMA B. BELL /WIF	Έ	ADI	ailing Address (Street DRESS SAME sposition (Name of	AS ABOVE			City or Town, State
mit. Page: certment of cortant: If I / injury or		1 ☐ Burial 2 ☐ Cramation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Spacify)  21. Signature of Funaral Service Licensee	SF		rematory or other place ILL MEMORY 22. Name and Addra	GARDEN	6-28   I	HEBRON,	
permi Deper Impo any ir		23a. Part 1. Enter the disease, of complication ahock, or heart failure. List only only care.	ons that caused the de-	ath. Do not	1213 JERS antar tha moda of dyin	EY ROAD;	SALISBU	RY, MD.	
Physician /Medical Examiner		3.	Fute M Dualo CARRO						Onset and Death
s be executed sician and bunel-transit	Examiner			0	sequence of):	Stock			crepay
tificete be ex g physician es the buriel	Cai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last							
v requires that the death certificate been signed by the attending phys should be deteched for use as the	Physician/Medi	d Part II. Other significant conditions contribu	ting to death but not re	asulting in the	a underlying cause giv	en in Part I.	23b. Did to	bacco use cont	tribute to the cause of death?
uires thet the signed by	þ	HISTER Conge	show the	भर्या .	Forluse	-	1 □ Y		3 Probably 4 Unknown  24b. Wara autopsy findings
9 S C	Completed			-			perform	med?	24b. Wara autopsy findings available prior to completion of causa of death?
ician: The lev certificate hes rector, page 2	Be C	25. Was case referred to medical examinar?				26. Place of Deat			13103 4210
To the Hospital or Attending Physician: The lew requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate hes been signed by the ettending physicompletely filled in by the funeral director, page 2 should be deteched for use as the	2	1 Yes 2 No Hospi	tal: Inpatient 2 [ Ba. Date of Injury (Month, Day Year)	28b. Time	e of 28c. Injury	4 LI Nursing Ho	me 5 Reside		
tal or Attenrs after dea	Certification:	a Could not be	Be. Placa of Injury - At building, etc. (Spec	home, farm, cify)	street, factory, office		28f. Location (SI City or Town		r or Rurai Route Number,
the Hospi hin 24 hou the Funer npletely fill	Medical		n: To tha bast of my kr On the basis of examir and manner stated.	nowledga, da nation and/or	invastigation, in my o	pinion, death occurr	ed at the tima, d	ate and place, a	nd due to the cause(s)
To To		29b. Signature and title of certifier	mo		29c. Licens	_		- /	(Month, Day, Year)
10		30. Nama and address of person who comple	ted cause of death (Ite	1	oe, Print)	Dome	Spla	no	2197
Sta Registra	-	31. Date filed (Month, Day, Year) JUN 25 1997	32. Registrar's Sign	neture Ra	dell				

Process sea v. sine a lake The state of the s A second of the 

	Plea		Print in Blac of Maryland / I	Depa	rtmer	t of I		and N	Mental Hyg		Rev non	21255
Decedant's Nam     DAVII		fla, Last) ANGUS		BIO	ONDI				2. Data of Daa Month	Day	Yaar 797	3. Tima of Death 1734
		on, giva street and nu GIONAL MEI	umber) DICAL CENTE	ER				wn, or L	ocation of Daath	4c. County	of Daath	00
			7. Aga (In yrs. last birthday)		1 Yaar Days	If Undar Hours	24 Hrs. Min.	8. Data of Birth (Month, Day February	Year)		placa (Stata or Foraign htry) nsvlvania	
Usual Rasidance of	of Decadant											-
10a. Stata	10b. County		10c. City, Tow	n or Loc	ation						1	Od. Insida City Limits
Maryland Wicomico Sa				Sali	lisbury							1 X Yas 2 □ No
10e. Straat and Numbar 722 Camden Ave.					10f. Zip Coda 21801			1	0g. Citizan of	What Cour	ntry?	

13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.)

722 Camden Ave., Salisbury,

Holloway Funeral Home

1 ☐ Yes 2 No Specify:

16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired)

22. Nama and Addrass of Facility

Consultant

20b. Place of Disposition (Nama of cematary, cramatory or other place)

Dua to (or as a consequence of)

Dua to (or as a consaquance of):

Salisbury Crematory

Diserse

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Tima of

**Funeral** Director 28a-f show å

**Physician** 

/Medical

**Examiner** 

15. Decedant's Education (Spacify only highast grada completed)

1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify)

1 Navar Marriad 2 Married

3 Widowad 4 Divorced

Elementary/Secondary (0-12)

17. Fathar's Nama (First, Middla, Last)

William A. Biondi

Helen Biondi/Wife

21. Signature of Funeral Service Licensaa

19a. Informant's Name/Ralationship (Type, Print)

12

20a. Mathod of Disposition

12. Was Decedant Evar in U,S.

1 K∑Yas 2 ☐ No If Yes, Giva Yaar or Datas: WW II

MO 1051

Armad Forcas

College (1-4or 5+)

traumatic event, the Medical Examiner must be notified at Directo 6 "natural", or items 23a Funeral þ Completed important: If item 27 is marked other than any injury or other traumatic event the 2006. Be Pages 1 and 2 should be 2

579-36-680

Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

ettending physicien and for use as the burial-transit The law requires that the death certificete be executed David Brindi been signed by the e should be detached t is certificate has be director, page 2 s

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certificat completely filled in by the funeral director;

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disaasa or condition rasulting in daath) Physician/Medical Examine Sequantially list conditions, if any, laading to Immadiata cause. Entar Undarlying Cause (Disaasa or injury that initiatad avants rasulting In daath) Last Part II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Part I. Completed by Be 25. Wes casa referred to medical axaminer? ၉ 1 Yas 2 No 27. Manner of Daath 1 DNatural Certification: 3 Suicida 29a. Certifian Medical PAINA

28a. Date of Injury (Month, Day Year) 5 Panding invastigation 2 Accidant 6 Could not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, office building, afc. (Spacify) 4 Homlcide 1 Certifying Physician: To the best of my knowledga, daath occurred at tha time, date end place, and dua to the causa(s) and manner as statad.
2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the causa(s) and manner stated. 29b. Signature and title of certifiar 31. Data filad (Month, Day, Yaar) JUN 23

29c. Licanse number

28c. Injury at Work?

1 ☐ Yas 2 ☐ No

29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

14. Race - Amarican Indian.

Government Banking

White

marthe

24b. Were autopsy findings availabla prior to complation of causa of death?

1 Yas 2 TLNo

Black, Whita, atc.

Specify:

MD 21801

18. Mothar's Nama (First, Middla, Maidan Sumama)

6/23/97

501 Snow Hill Rd., Salisbury, MD 21804

Dyer

24a. Was an autopsy performed?

Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify)

26. Placa of Death (Check only ona)

1 Yas 2 No

28d. Dascribe how injury occurred

Jeanette

19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda)

16b. Kind of Businass/Industry

20c. Location - City or Town, Stata

23b. Dld tobacco use contributa to the cause of death? 1 No 3 Probably 4 Unknown

Salisbury, MD

parson who complated causa of daath (Item 23a) (Typa, Print) erton PRINC SALISBURY

1 Impatiant

Registrar **DHMH 16 Rev 6/95** 

State

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State of Maryland / Department of Health and Mental Hygiene Q 7

21256

						Ce	rtificat	e of	Death			Reg. No.		Cat 1 140	0
	Division		1. Decedent's Name (First, Middle, La	ast)							2. Dete of D	eath	V	3. Time o	of Deeth
	Physic /Medi		CATHERINE	MARY			CLAR				Month JUNE	27, 1	99 <b>7</b>	9:5	7 AM
	Exami		4a. Fecility Neme (If not institution, git	ve street and num	iber)				4b. City, To	wn, or L	ocation of Dea		ty of Deetl	1	
			7885 GORDON COU	JRT AP	T 571				GLEN	BUR	NIE	ANNE	ARUN	IDEL	
	<sub>o</sub> Funeral Director		5. Social Security Number 6. 5 217.03.0481	Sex 11 M 2□F	7. Age (In yrs. las 83	st birthday Yrs.	If Under Months	1 Year Days		24 Hrs. Min.	8. Date of B Month, D APRIL	irth 8 , 1914	9. Birti Coi MAF	nplace (Stete o	or Foreign
	pu .		Usuel Residence of Decedent  10a. State 10b. County		10c. City,	Tourn or I	continu								
	Ba-f short	ctor	MARYLAND ANNE AF	RUNDEL			BURNI:	E						10d. Inside C	Sity Limits S 2 🔯 No
	th with th	Funeral Director	7885 GORDON COURT	ſ			10f. Zip	Code 2106	50			10g. Citizen o		intry?	
020	ges 1 end 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23s or 28s-f show or other treumatic event, the Medical Examinat must be nutified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Deced Armed For 1  Yes If Yes, Give Year or Da	2ĎLNo ∍				Hispanic Ori den, Mexicer Specify:		ecify Yes or N Rican, etc.)		ace - Americack, White		
21215-0020	n "natur	Completed	15. Decedent's E (Specify only highest gr	ede completed)		16e. Dece (Give life.	dent's Usue kind of wor DO NOT us	el Occu rk done se retire	pation during mos	t of work	ring	16b. Kind of	Business/I	ndustry	
212	d with giene.	E O	Elementery/Secondary (0-12) UNKNOWN	College (1-			MAKER		-,			OWN H	OME		
Maryland	uld be file Mental Hyg rked otha	To Be C	17. Father's Name (First, Middle, Last GEORGE O. REUS								e (First, Middle IY M. A	e, Maiden Sume DLER	eme)		
	Health end 2 showers the street of the stree		19e. Informent's Name/Relationship (SEYMOUR A. EWING	Type, Print) (FRIENI							e/Route Numi RLISLE	ber, City or Tow	n, State, Z 7013	ip Code)	
Baltimore,	permit. Pages 1 end Depertment of Health Important: if Item 27 any Injury or other tt once.		20a. Method of Disposition 1		tate CUME	ce of Disponence, cre BERLA	osition (Name and Name  ne of ther ple	MEM.	17	Date 7/1/97		ENNSE	Fown, State BORO TW COUNTY		
alti	Sepertrr Sepertrr mporta any inju		21. Signature of Funeral Service Licer	nsee					ess of Fecili			TON FUN			, 111
m	20E = 8		Muchael 1	15	110	)	1 SECO	ND	AVE	S.W.		BURNIE,			21061
31	Physician	70.00	23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plications that one cause on	used the death. on ine.									Approximat Intervel Bet Onset end	ite itween
7	/Medical Examiner	Ш	Immediete Ceuse (Final disease or condition	My	ocardi	al,	" fare	tun	1					Unkur	7.2-0
Н	Cxammer	L.	resulting in death)		Due to (or e	s e conse	quence of):				\			0 11 .00	-0,00
	be sit	F		h. Ather	oscles	he	Card	wo	scule	er	Dree	afe	į		
60,	certificete be executed nding physician end use as the bunel-transit	Immediate Ceuse (Final disease or condition resulting in death)  Due to (or es e consequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events  Due to (or es e consequentially list conditions, if any, leading to immediate cause. Enter Underlying c.													
x 68760,	ng phys	Medicai	thet initiated events resulting in death) Lest	d	Due to (or ea	s e consec	quence of):								
<b>B</b> 0	attendi for use	Physician/		u											
	tt the de by the a rtached	ysic	Part II. Other eignificant conditions of	ontributing to dea	th but not resulti	ng in the u	inderlying ca	ause gi	ven in Pert I		23b. Did	tobacco use o	ontribute	to the cause	of deeth?
P.0	that the ed by detac								-		1□	Yes 2 No	3□ Pro	obably 4 🗆	Unknow
ds	The law requires that the death ste has been signed by the atter page 2 should be detached for u	d by									Ode We		24h V	Vere eutopsy 1	findings
Ö	v require been si should	Completed									perf	s en eutopsy ormed?	0	vailable prior to ompletion of co	to
Ä	has ge 2	du										,	0	f deeth?	
a											1 🗆	Yes 2 No	1	☐ Yes 2☐	l No
5	- 0 -	Be	25. Wes case referred to medical exeminer?	Hospital:				Ott	nor:		h (Check only				
ō	Phys this ral di	. To	1  Yes 2 No  27. Manner of Death	1 🗆 In		VOutpetier		^				idence 6 🗆 O		ify)	
Division of Vital Records,	tending leath. tor: After the fune	Certification:	1 ☑Naturel 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not b.	2	, Day Yeer)	3b. Time o Injury	М		rk? IYes 2□I	No		how injury occ			
<u>&gt;</u>	Ital or Attend Its efter death rel Diractor: /		4 ☐ Homicide determined	building	of Injury - At home g, etc. <i>(Specify)</i>		, 				City or To	(Street end Nun wn, State)			iber,
	To the Hospital or At within 24 hours efter of To the Funerel Diracl completely filled in by	Medical	29a. Certifier (Check only one)	ysicien: To the b niner: On the bas end menne	is of exeminetion	dge, death n end/or in	vestigation,	In my c	pinion, deal	d place, th occurr	end due to the ed et the time	ceuse(s) end r date and plece	nenner es , end due	steted. the cause(s	5)
	To the within 2 To the comple		29b. Signature and title of certifier  The complete of the com	_ HD			G	236	se number			29d. Date sign	27	97	
			30. Name and address of person who BERCOVITZ	completed cause	of death (Item 23	3e) (Type, 1+15	Print)	-w/s	my R	ASA	05113	MD	2112	22	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Rec	sistrer's Signeture	· A	della								

mark made of

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 2 | 257

			Certificate of Death	R	eg. No.	
	S		Decedent's Neme (First, Middle, Last)	2. Deta of Dae	th	3. Time of Death
	Physici /Medic		Steven Howard Chiodi	JU ~	Dey	97 1319
	Examir		4a. Facility Neme (If not institution, give street end number)  4b. City, Town, or Lo	cation of Daath	4c. County o	f Death
		4	155 MONTICELLO AVE ANNA	100/15	H	15
	Funeral Director		5. Social Security Number 6. Sax 1 Naga (In yrs. last birthdey) 1 Nonths Vrs.  468-80-3456 7. Aga (In yrs. last birthdey) Yrs. 31  Hours Min.	8. Dete of Birth (Month, Dey March	Year)	9. Birthplace (State or Foreign Country) Minnesota
	and **		Usuel Residence of Decedent  10a. Stata 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Ba-f sho	Funeral Director	MD Anne Arundel Annapolis			1 X Yes 2 □ No
	vith th	Dire	10e. Street end Number 10f. Zip Code	1	0g. Citizen of Wh	
	ath v	rai	155 Monticello Avenue 21401			d States
21215-0020	72 hours after death with the Maryland natural; or items 23s or 28s-f show deal Examiner must be notified at	þ	11. Marital Status  12. Was Decedant Evar in U,S. Armed Forcas?  1 □ Never Married 2 ▼ Married  1 □ Never Married 2 ▼ Married  1 □ Yas 2 ▼ No It Yas, Give Yeer or Detes:  13. Was Decedant of Hispanic Origin? (Spe It Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ▼ No Specify:	ecity Yas or No- Ricen, etc.)		- Americen Indian, White, etc.
2-0	"natural",	ted	15. Decedent's Education 16e. Decedent's Usuel Occupation (Specific and highest and a completed)	ina	16b. Kind of Bus	
21	within 72 ho iene. then "netur the Med cel	nple	(Specify only highast grada completed)  (Giva kind of work done during most of work)  Elamantary/Secondary (0-12)  Coilega (1-4or 5+)	ing	Automo	bile
		Completed	5 Executive			cturing
Pu	8 0 0 ×	Be	17. Fether's Neme (First, Middle, Last)  18. Mother's Name  19. The second of the seco		Maiden Sumeme	)
2	should be ind Mentel marked o	2		e Cole		
Maryland	d 2 strau		19e. Informant's Name/Relationship ( <i>Type, Print</i> )  William M. Carter (Father-In-Law) 39 Southgate Ave. A			
	is 1 and if Health item 27 other tr		20a. Method of Disposition 20b. Placa of Disposition (Neme of			Olty or Town, Stete
Baltimore,	permit. Pages Department of I Important: If ite eny injury or o		1 ☐ Burial 2 ☐ Gremetion 3 ☐ Ramoval from Stete 4 ☐ Donetion 5 ☐ Other (Specify)  Ft. Lincoln Crematory July	2, 199	7 Brentw	ood, Maryland
Bal	Departiment Imported on Incorporate On Incorporate		21. Signature of Funcial Service Licensee  22. Name end Address of Fecility ohn 147 Duke of Glouces	M. Tay: ter St.	lor Fune Annapol	ral Home, Inc. is, MD 21401
			23a. Part1. Enter tha disease, or complications that ceusad tha deeth. Do not enter tha mode of dying, such as cardiac of shock, or haert teilure. List only one ceuse on each line.	or respiretory arr	est,	Approximata Intervel Between
V	Physician		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	,		Onset end Deeth
	/Medical Examiner		Immediata Causa (Final disease or condition assulting in death)  e Shotgur Wound He	Ad		UNK
		e	The to (or es a consequence of):			1
	uted	Examiner	b		1	
ď.	tificate be executed ig physician and es the burial-transit	Еха	Sequentieily list conditions, if eny, laeding to immediate cause. Enter Underlying			
68760,	te be yslcia	Physician/Medical	Ceuse (Disease or Injury that initiated events			
-	₽ p 0	Med	resulting In death) Lest			
Box	death cer le attendin ed for use	an/	d			1
	he att	sici	Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Pert I.	23b. Did to	bacco use cont	ribute to the cause of death?
P.0	res that tha de ilgned by the s be deteched	by Phy		1 🗆 Y	25,46	3 Probably 4 Unknown
Records,	been s	Completed b		24e. Was a perform	n eutopsy ned?	24b. Were eutopsy findings evellable prior to completion of cause of death?
	0 - 5	COL		1 □ Y	s 2 No	1 ☐ Yes 2 ☐ No
Vital	Physician: The this certificate ral director, pag	Be	25. Was cese reterred to medical 9x8prinar? 26. Placa of Death	(Check only or	ne)	
of	S w D	2	12(Yas 2□ No Hospitel: 1□ Inpatient 2□ ER/Outpetient 3□ DOA Other: 4□ Nursing Hol		ence 6 Other	
	After t funers	on	1 Naturel 5 Pending (Month, Dey Year) Injury Work?	28d. Describe h	ow injury occurre	d
Sign	Attending r death. ector: After by the fune	cat	2 Accident investigation C 30/97 UNXM 1 Yes 2 No	SHO	7 3	er
Division	after death Director: A	Certification:	4 Homlcide  28a. Place of thjury - At home, ferm, street, factory, office building etc. (Specify)	City or Town	n, Stete)	r or Rural Routa Number,
_	pital ours a eral filled			HUW	ALVOIT	s, MO.
	To the Hospital or Attending Ph within 24 hours after death. The Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred et tha tima, data and place, and place, and control of the best of axamination and/or invastigation, in my opinion, death occurred and manner steted.			
	To the	Me	29h Signature and title of certifier	2	9d. Date signed	(Month, Day, Year)
	->-0		Mellin R. Deputy D06054		6/20	197
			30. Name end eddrass ot person who completed causa of daeth (Itam 23a) (Type, Print)		0/30	/ '
			30. Name end eddrass of person who completed causa of daeth (Itam 23a) (Type, Print)  William Purones, MD 695 Amer	ICA	2103	5
	Sta Registr		31. Data filed (Month, Dey, Yeer) 32. Registrer's Signeture			

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State of Maryland / Department of Health and Mental Hygiene 97 2 | 258

		Certificate of Death	Reg. No.
Physician	Decedant's Nama (First, Middle, Last)		2. Data of Death Month Day Yaar
/Medical	PHILLIP G. COLE		JULY 2, 1997 5:45 AM
Examiner	. Facility Nama (If not institution, giva street and number) PHYSICIANS MEMORIAL HOSPITAL	4b. City, Town, or Lo	cation of Death  4c. County of Death  CHARLES
Funeral	Social Sacurity Number 6. Sax 7. Aga (In yrs. last birth	Months Days Hours Min.	8. Data of Birth (Month, Day, Year) 9. Birthplace (State or Foreig
Director	218-14-3405   18 M 2	rs.	OEC. 24, 1904 MARYLAND
yland	ia. Stata 10b. County 10c. City, Town	or Location	10d. Insida City Limit
the Marylar 28s-f show notified at	MARYLAND CHARLES BEL A	LTON	1 ☐ Yas 2 € N
or 26	e. Street and Number	10f. Zip Coda	10g. Citizen of What Country?
23a ran w	8150 BEL ALTON NEWTOWN ROAD	20611	UNITED STATES
thed within 72 hours eiter death with the Maryland ther then "naturel", or items 23s or 28s-f show the the Medical Exercitor must be notified at the Completed by Funeral Director	. Marital Status  1 ☑ Navar Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedant Evar In U,S. Armed Forcas?  1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas:	<ul> <li>13. Was Dacedant of Hispanic Origin? (Spelf Yas, specify Cuban, Maxican, Puarto I</li> <li>1 ☐ Yas 2 ☑ No Specify:</li> </ul>	ncify Yas or No-Rican, atc.)  14. Race - American Indian, Black, Whita, atc.  Specify: BLACK
ygiene.  The then *nature!,  It, the Wedical Exercises.  Completed by	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Decedant's Usual Occupation Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Businass/Industry PRIVATE
Hygiene officer than officer than	2 . Father's Nama (First, Middla, Last)	LABOR 18 Matheda Name	(First, Middle, Maiden Surname)
	DAN COLE		
and Mental is marked o			GROSS COLE  Il Route Number, City or Town, State, Zip Code) 20611
ento de la composición del composición de la composición de la composición de la composición de la composición de la composición del composición de la composición de la composición del composición de la composición de la composición del composición del composición del composición del composición del composición del composición del composición del composición del composi	7764-76		NEWTOWN RD. BEL ALTON, MD
- 1 5 5	a. Mathod of Disposition 20b. Place of	Disposition (Name of	Data 20c. Location - City or Town, Stata
reges nent of int: If its ury or o	Abunal 2 Cramation 3 CHamoval from Stata	HEART CHURCH CEMETER	/7/97 LA PLATA, MARYLAND
Department Important: Important: I any injury o	LEON THORNTON	22. Nama and Addrass of Facility  THORNTON FUNERAL H	OME
	3a. Part1. Entar tha disaasa, or compilcations that caused tha death. Do no shook, or heart failura. List only one cause on each line.	3439 LIVINGSTON ROAD anter the mode of dying, such as cardiac of	D INDIAN HEAD, MD 20640  r raspiratory arrast, Approximata Interval Between
Physician /Medical Examiner	nmediata Causa (Final sease or condition suiting in death)  Due to (or as a co	Onset and Death  + T W	
g physician and as the bunal-transit	equantially list conditions, any, leading to immediate use. Enter Undarrying at initiated evants  Dua to (or as a co	m 4 Mon.	
n certification of the certifi	sulting In death) Last  d	nadquance off.	
deatte	if II. Other algorificant conditions contributing to death but not resulting in	tha undarlying causa givan in Part I.	23b. Did tobacco use contribute to the cause of deatl
es met the death certification of the strending be detached for use by Physician/N			1 ☐ Yes 2 ☐ No 3 ☐ Probably Unkno
seen s should			24a. Was an autopsy performed?  24b. Wara autopsy findings available prior to completion of cause of death?
			1 Yas 2 No 1 Yas 2 No
Be Be	. Was casa raferred to medical axaminar?	26. Place of Death	(Check only one)
는 물을 <b>느</b>	1 Yas 2 No Hospital: Inpatient 2 ER/Outs		na 5 Rasidance 6 Othar (Specify)
fune fune	. Mannar of Death 28a. Data of Injury 28b. Til  Data value 5 □ Panding (Month, Day Year) Inj  □ Accidant invastigation	ma of ury 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Dascribe how Injury occurred
within 24 hours after death. To the Funeral Director: After toompletely fixed in by the funeral Medical Certification:	3 ☐ Suicida 6 ☐ Could not be determined 28a. Place of Injury - At homa, farm building, etc. (Specify)	m, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
within 24 hours to the Funer completely fill	la. Certifiar (Check only one)  Certifying Physician: To tha best of my knowledga, Medical Examinar: On the basis of examination and and mannar stated.	daath occurred at tha tima, data and place, a for invastigation, in my opinion, daath occurre	and dua to the causa(s) and manner as stated.  and at tha tima, data and place, and dua to tha causa(s)
Melthir Melthi	b. Signature and title of certifier	29c. Licansa number	29d. Data signed (Month, Day, Year)
	Thon And	D-20629	7/2/47
	Name and addrass of person who completed causa of death (Item 23a) (T		
	GEORGE WATHEN M.D. 11345 PEMBROOKE S		DORF MD. 20603
State	Data filed (Month, Day, Year) 32. Registrar's Signatura	n Dozaz 100 Will	- NO. B. MANNEY

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97

						Certific	cate of	Death		Reg. N	ю.		
	Dhysis		1. Decedent's Name (First, Middle, Las	st)		V			2. Date of D Month		ay	Year 3	. Time of Death
	Physic /Medi		Darlene M. Carter			_			June		1997	Tear	6:38 am
	Examir		4a. Facility Name (If not institution, give	e street end number)				4b. City, Town,	or Location of Dea		c. County o	of Deeth	
			Memorial Hospital					Cumber			Alle	gany	
	Funeral Director		5. Social Security Number 6. S 299-52-2520  Usual Residence of Decedent	ex 7. Ag  ☐ M 2 <b>2</b> F	e (In yrs. lest bi		Inder 1 Year oths Days		Ain. 8. Date of B	orth C-51	9	9. Birthplace Country Adrylan	d (State or Foreign
	and		10a. State 10b. County		10c. City, Tow	n or Location	1					10d	Inside City Limits
	Mary f sho	0	Maryland Allega	ηγ	Cumbe	erland							1 X Yes 2 No
	28a	Director	10e. Street end Number 301 Baltir				f. Zlp Code			10a. C	itizen of W	hat Country?	
	s 23a or	eral DI					215				U.S.A.		
21215-0020	72 hours efter death with the Maryland "netural", or flerns 23a or 28a-f show oficial Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 Narried  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:			specify Cub	Hispanic Origin'i an, Mexican, Pu Specify:	(Specify Yes or Nuerto Rican, etc.)	0-	Black	- American I c, White, etc. White	ndian,
5-(	d within 72 ha piene. r than "netu	Completed	15. Decedent's Ed (Specify only highest gre	ucation de completed)	16a	Decedent's	Usuel Occup	pation during most of	workina	16b. I	Kind of Bus	siness/Indust	ry
121	within ene.	mp	Elementary/Secondary (0-12)	College (1-4or 5	5+) Nu			during most of d)	vi oritini g	Niu	reina		
7			17 Enthor's Name (First Alidela Local)	0	INC	irsing As	SISICITI	40.00.0.1			rsing		
and	d is o	Be	17. Father's Name (First, Middle, Last) Robert Reger						Name (First, Middle	, Maide	n Sumame	)	
Ž	2 should be nend Mental is marked o	P_0							la Simpson				
, Maryland			19a. Informant's Name/Relationship (7 Gary F. Carter	Husband		7 Mount			Rural Route Numi Mount Savo				de) 1545-
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 is any injury or other tre once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place of cemete Maryland	ry, crematory	or other ple		Date 01-Jul-97			oity or Town, nd, Mai	
Balt	permit. Pa Departmen Important: any injury once.		21. Signeture of Funeral Service Licen	Durch	/			ess of Facility  Il Home, 5	7 Frost Ave	, Fros	stburg,	MD 21:	532
	-		23a. Part. Enter the disease, or companies, or heart failure. List only	olications that caused one cause on each lin	the death. Do	not enter the	mode of dyi	ng, such as care	diac or respiretory	errest,		Inte	proximate erval Between
H	Physiclan /Medical		Immediate Cause (Final disease or condition	0	riiti	Ш						On	set and Death
п	Examiner		resulting in death)	a	Due to (or es a	consequence	e of):						
	sit s	ine		h								i	
,	certificete be executed Iding physician and Ise es the buriel-trensit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (or as a	consequence	of):						
68760,	ysicia e bur	cal	that initiated events	c	Due to (or as a	CONSEQUENCE	of):					-	
	ing phy e es th	Medical	resulting in death) Last		540 10 (01 43 4 1	oonsequence	01).						
Box	ath co	Physician/		d									
o	the death y the etter sched for u	yslc	Part II. Other algnificant conditions co	ntributing to death be	ut not resulting l	the underly	ing cause giv	en in Part I.	23b. Dld	tobacc	o uae cont	ribute to the	causa of death?
s, P.O.	that led b	by Ph	Dantes	Hellery					1	Yes	2□ No	3 Probabl	y 4 Unknown
Records	law requires as been sign 2 should be								24a. Was	en euto	opsy		eutopsy findings ble prior to
900	S C	Completed							-	/			etion of cause
ď	The I	E C							1 📮	Yes 2	2□No	1.2 Ye	es 2 No
of Vital		Bec	25. Was case referred to medical	/				28. Place of I	Death (Check only	one)	<u> </u>		
2	Physician: this certific ral director,	To	examiner?	Hospital: 1 Inpatie	nt 2 ER/Ou	tpatient 3	DOA Oth	ner: 4 Nursin	g Home 5 ☐ Res	idence	6 □Other	(Specify)	
	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		Time of njury	28c. Inju		28d. Describe				
0	Attending or deeth.  Betor: After by the fune	atic	2 ☐ Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , , , , , , , ,	M		Yes 2 □ No					
Division	5 # # E	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc		rm, street, fa	ctory, offica		28f. Location City or To			r or Rural Ro	ute Number,
	To the Hospital within 24 hours e To the Funeral C completely filled	edical (	29a. Certifier 1 Cartifying Phyone) 1 Madical Exam	ralcian: To the best of inar: On the basis of and manner sta	examination an	, death occur d/or investiga	rred at the til ation, in my o	me, date and pla pinion, death o	ace, and due to the ccurred at the time	cause(s	s) and man nd place, ar	ner as stated nd due to the	t. cause(s)
	ro th withir ro th	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Da	ate signed	(Month, Day,	, Year)
	3		1. Mccue	eru			D 4	4712			7/1	197	
(	10/1		30. Name and address of person who co	ompleted cause of de	eath (Item 23a)	(Type, Print)				_			
	jus		Dr. N. McCullough	, 921 Set	on Drive	, Sui	te C,	Cumber1	and, MD	215	02		
	Sta	te	31. Date filed (Month, Day, Year)		ir's Signature	,	•		•				

MARYLAND

RETAIL.

3. Time of Death

10d. Inside City Limits

1 ☐ Yes XX No

5:18 am

tille it of Fleatiff and Ment	airiyyiche	7	1		1		Ē.
ificate of Death				Bures		See	*
ilicale di Dealli	Reg No						

**Physician** /Medical **Examiner** 

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

25. Was case referred to medical examiner?

1 Yes

27. Manner of Death 1 Natural

2 Accident 3 Suicide

4 Homlcide

29a. Certifie

29b. Sign

2 No

5 Pending investigation

6 Could not be determined

4c. County of Deeth

**Funeral** Director

Director

Funeral

þ

Completed

Be

2

the Maryland

is 23a or 28a-f show items 23a death the Medical Examiner filed within 72 hours eftar Hygiene. ŏ "naturai". marked other than permit. Pagas 1 end 2 should be file Department of Haatth and Mental Hy important: if item 27 is marked othe any injury or other traumatic event

Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

burial-transit pue Box 68760 ettanding physician thet the death certificate be the 98 ŏ signed by the et d be detached for P.O. of Vital Records, peen has paga 2 certificata

COSGROVE

EDWARD

Division

• Funeral I To the Within 2 State

Hospital or Attending Physician: 24 hours after death. funeral Director: After in by

Physician/Medicai

þ

Completed

Be

٩

Certification:

edicai

State of Maryland / Department of Health and Mental Hydiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Yaar EDWARD RICHARD COSGROVE June 30, 1997 4b. City, Town, or Location of Deeth 4a. Facility Name (If not institution, give street and number) Memorial Hospital Cumberland Allegany If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **X**M 2□ F Months Days Hours Min 72 Yrs. 318-24-2344 APRIL 3 1925 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location MARYLAND ALLEGANY CUMBERLAND 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21502 12009 KITE AVE (POTOMAC PARK) 12. Was Decedent Ever in U,S. Armed Forces? 12 12 No If Yas, Give Year or Dates: WW 1 1 Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 A Married 1□Yes 2√2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRESIDENT CYCLES COSGROVE CYCLE CO. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CATHERINE NEE EDWARD A. COSGROVE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) NANCY COSGROVE WIFE 12009 KITE AVE CUMBERLAND MARYLAND 21502 20a. Method of Disposition

→ Burial 2 □ Cremetion 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) SUNSET CEMETERY JULY 3 1997 CUMBERLAND MARYLAND 21. Signature of Funeral Service Licer 22. Name and Address of Fecility MERRITT-ADAMS FUNERAL HOME ox enul 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heer failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in death) CARDIOPULMONARY ARREST Due to (or as a consequence of):

MASSIVE MI

Due to (or as a consequence of):

SEVERE INTERSTITIAL FIBROSIS O2 DEPENDANT

Due to (or es e consequence of).

1 Yes 2 No

3 Probably 4 Unknown

Approximate Interval Between Onset and Death

Less than

one hour

Less than

one hour

Less than

one year

24a. Was an autopsy performed?

24b. Were autopsy findings evaileble prior to completion of ceuse of death? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

23b. Did tobecco use contribute to the cause of death?

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

🔟 Certifyling Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated. edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

d. Date signed (Month, Day, Year)

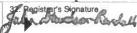
29c. License number

D 16041

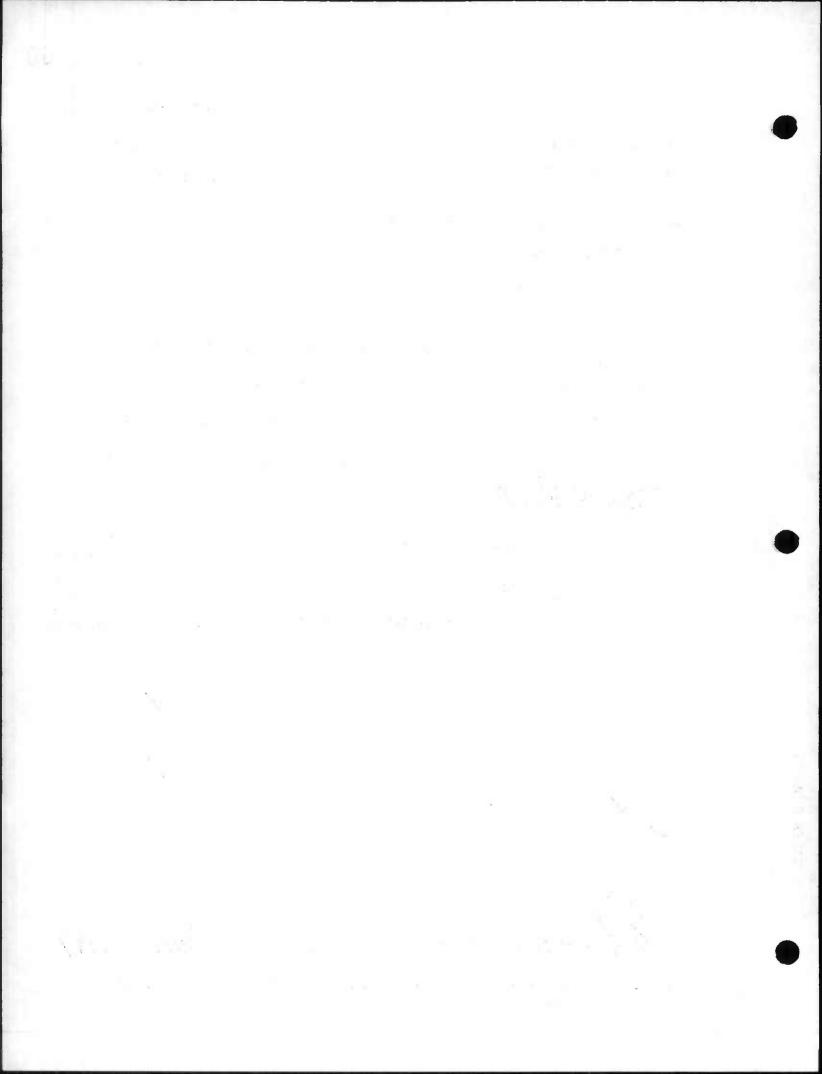
30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

T. Williams, Memorial Hospital Medical Bldg., Cumberland, MD 21502

31. Date filed (Mr.



Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Year Katie Mae Calhoun /Medical JUNE 30 1997 10:20AM 4a. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Sacred Heart Hospital Cumberland Allegany 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Feb., Po., Year 927 7. Age (In yrs. lest birthday) Birthplece (State or Foreign
 Montry) **Funeral** 1□ M 2□ F Deys Hours 213-22-3650 76 **Yrs** Director Usuel Residence of Decedent death with the Meryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Merylan Depertment of Health end Mentel Hygiene.
Important: If item 27 is marked other then "nature!; or items 23a or 28a-f show any injury or other traumatte event, Ita Madical Examiner must be notified at any injury or other traumatte event, Ita Madical Examiner must be notified at MD Allegany Rawlings Y□ Yes 2□ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21016 McMullen Highway 21557 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1□ Yes Z□ No Baltimore, Maryland 21215-0020 þ Specify: white ₩ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Benjamin Dorsey Katie (MacMullan) 2 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 12613 Wilson Lane Cumberland MD 21502 Sandra Cline-daughter 20e. Method of Disposition

1 Burial 2 Cremetion 3 Removel from State 20b. Place of Disposition (Name of cemetery, crematory or other piece) 20c. Location - City or Town, Stete Restlawn Memorial Gardens 07/03 LaVale MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Scarpellii Funeral Home Cumberland MD 21502 23a. Part! Enter the disease, or complications that cause d the death. Do not enter the mode of dylng, such as cerdiac or respiretory errest, show or heart tailure. List only one ceuse on each line. **Physician** + Cell CARCINOMA /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Due to (or es e consequence of): Examiner iclen end burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): ettending physiclen for use as the buna Box 68760 Physician/Medical Due to (or as a consequence of): Division of Vital Records, P.O. Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. the be detached 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24a. Was an autopsy performed? 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? Completed peen hes certificete 1 ☐ Yes 2 ☐ No Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certifice 25. Wes cese referred to examiner?
1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Be Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient P 2 ER/Outpetient 3 DOA funeral 28e. Dete of Injury (Month, Day Year) 27. Menner of Deale 28d. Describe how injury occurred Certification: Injury et Work? 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident filled in by the 6 Could not be determined. 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide 29a. Certifier Certifying Phyelcian: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. To the Vithin 2 29b. Signature and titles of 29d. Date signed (Month, Dey, Yeer) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gary Wagoner, M.D. Bishop Walsh Drive Cumberland MD 21502 Tal Haddinsebarraie

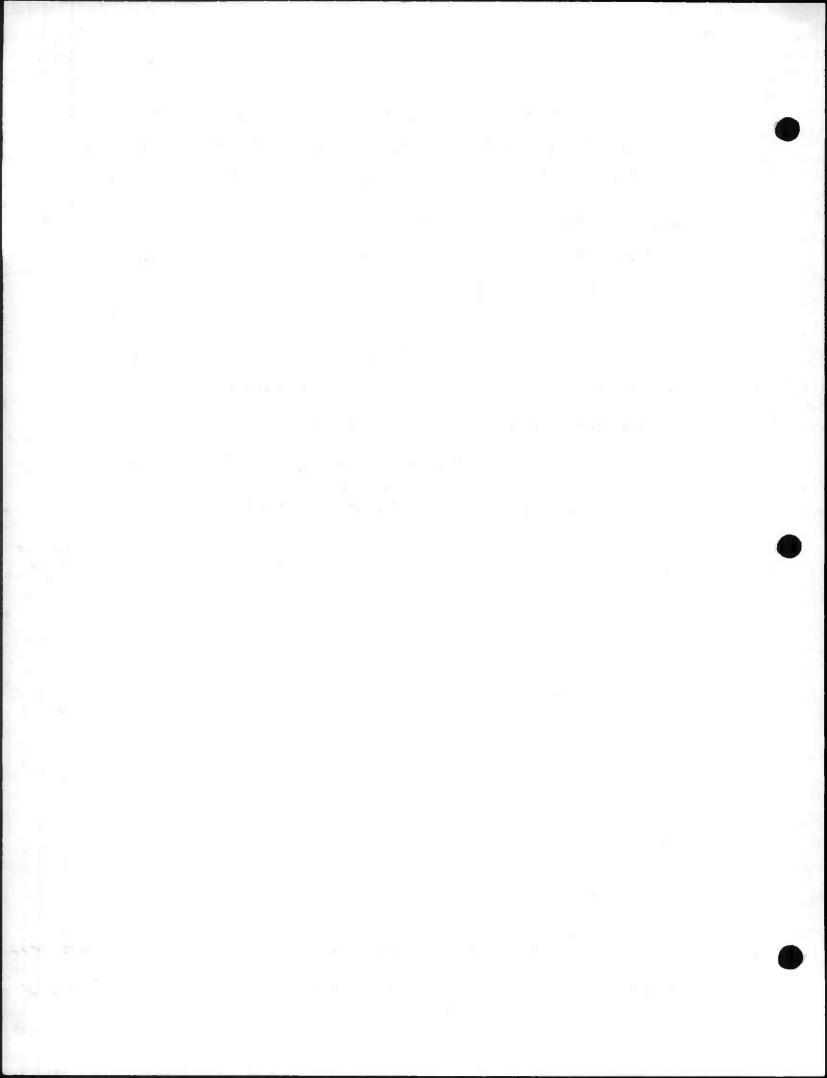
State Registrar

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Year Emera S. CULVER Culver JUNE 16, 1997 6:37 P /Medical 4e. Fecility Name (If not institution, giva street end numbar) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY Baltimore 7. Age (In yrs. last birthday) If Undar 1 Yaar 5. Social Security Number If Under 24 Hrs. 6. Sex 1X M 2□ F 8. Data of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) **Funeral** Yrs. Director 222-14-1044 Jan. 26, 1926 DE. Usual Residence of Decedent deeth with the Meryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or Items 23s or 28a-f show traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 No Director De. Sussex Laure1 10e. Street end Number 10f. Zip Code 10a. Citizen of What Country? Rt.3 Box 208C 19956 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, atc.) permit. Pages 1 and 2 should be filed within 72 hours effer of Deportment of Heelih and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Item any Injury or other traumatic event, the Medical Exercises. 1 ☐ Yes 2 X No It Yes, Give Year or Detes: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 ☐ Divorcad White Completed 15. Decedent's Education ify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind ot Business/Industry (Specify only highest g Elementery/Secondary (0-12) College (1-4or 5+) Farmer Poultry 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Ray Culver Eva Hitchens Culver 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Betty E. Culver, Wife Rt. 3 Box 208C Laurel, De. 19956 20e. Method of Disposition

1 Burial 2 Cremetion 3 Removal from Stete 20b. Place of Disposition (Nama of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 4 ☐ Donetion 5 ☐ Other (Specify) Mt. Pleasant Cemetery 6-21-97 Laurel, De. 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Fecility Short Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert teilura. List only one ceuse on each line. 700 West St. Laurel, De. 19956 **Physician** Two-ty-Tive Immadiate Cause (Final disease or condition resulting in death) /Medicai Hemorh oge Examine poys Due to (or es e consequenca ot): Examiner sician end buriel-transit Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Lest Due to (or as e consequence of): physician the buriel Box 68760 Physician/Medical Due to (or as e consequenca of): Pert II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco uea contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed 1 Yes 2 No 1 Yes 2 No certificate Division of Vital Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1 Naturel 5 Pending investigation 1 TYes 2 TNo 2 Accident 6 Could not be 3 Suicida 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, tactory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physicien: To the best ot my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated. within 2 29b. Signeture and titla of certifier 29c. License numbar 29d. Date signed (Month, Day, Yeer) RE1-200 30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print) Reymond North Worke STORET Bolting Mary land Horon 600 32. Registrar's Signature State JUN 24 1997 Jalia Davidson Rardell Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dey 1997 ear **Physician** June 27 Clouser Mildred 1:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury, MD Wicomico Salisbury Center: Genesis ElderCare ff Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Director 222-01-8630 81 Oct.27, 1915 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1⊠ Yes 2 No Director Wicomico Salisbury 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 300 Lemmon Hill Lane 21801 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Giva Year or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Black, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 1 No þ Specify: 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Alfred Baker Lola Tatum Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Clouser/ Son 600 Pelham Drive Waynesboro, VA 22980 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 6-30-97 Delmar, Delaware St. Stephens Cemetery 21. Signeture of Funeral Servica Licenses 22. Name and Address of Facility Short Funeral Home, Inc. Short-Hannigan Hoely 13 E. Grove St. Delmar, DE 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart for fure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Causa (Final diseese or condition resulting in death) /Medicai **Examiner** Physician/Medical Examiner The law requires that the death certificate be executed the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last physician Due to (or as a consequence of): use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? the 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ page 2 should be 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Was an autopsy Completed performed' After this certificate hes 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residenca 8 Other (Specify) Certification: To 3□ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation within 24 hours efter death. To the Funerei Director: A 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year)

10

Box 68760

P.0.

Division of Vital Records,

William H. Robins, M.D.
Date filed (Month, Day, Year)

32. Registrar's Signatura State JUN 3 0 1997

141 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

chi Davideor Rardall

1104 Healthway Dr., Salisbury, MD 21804

DHMH 16 Rev 6/95

Registrar

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0.7

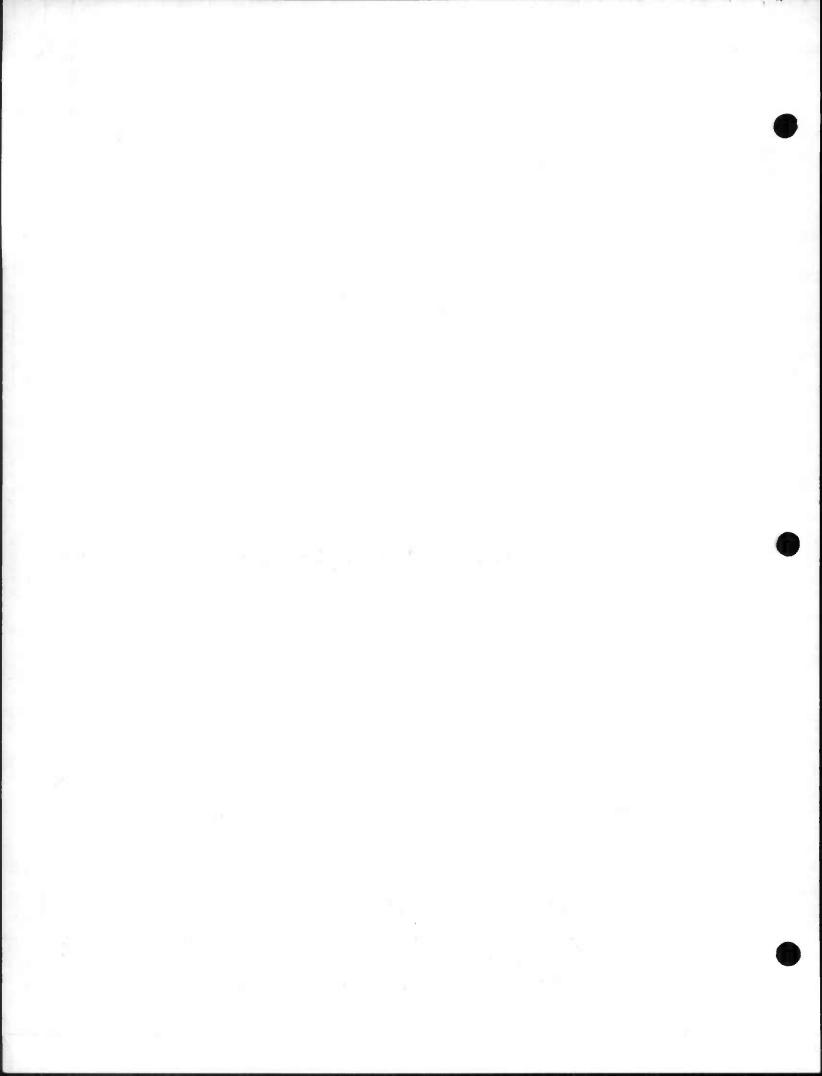
			Certificate of Death		Reg. No.	1 6	1204	
			1. Decedent's Name (First, Middle, Last)	2. Data of Dea	ath	.7%	3. Time of Death	_
	Physici /Modia		George Evans Duvall	Month July	Day O1	Year	4:45AM	
1	/Medio Examir		4a. Facility Nama (If not institution, give street and number)  4b. City, Town, or Loc				7.77/11	
			Anne Arundel Medical Center Annapoli	s	Anne	Arui	ndel	
	Funeral		5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs.	8. Date of Birti (Month, Day			ca (Stata or Foreign	
	Director		212-30-3586 1 M 2 F 87 Yrs. Months Days Hours Min. Usual Residence of Decedent	May 18		Mary]		
	hend was		10a. State 10b. County 10c. City, Town or Location			100	I. Inside City Limits	
	Many Feet	to	MD Anne Arundel Annapolis				1 Xes 2 □ No	
	28s	Funeral Director	10e. Street and Number 10f. Zip Coda		10g. Citizen of W	hat Countr	17	-
	3a o	<u>E</u>	1007 Moss Haven Court 21403		Unite	ed Sta	tes	
	deet	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	cify Yas or No-		- American	Indian,	
21215-0020	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelih and Manial Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mexical Examiner must be notified at once.	by	Armed Forces? If Yas, specify Cuban, Mexican, Puerto F  1 □ Navar Married 2 □ Married  1 □ Yas 2 □ No  If Yas, specify Cuban, Mexican, Puerto F  1 □ Yas 2 □ No  If Yas, specify Cuban, Mexican, Puerto F  1 □ Yes 2 □ No Specify:  1 □ Yes 2 □ No Specify:	fican, atc.)		white, at		
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7	w bed w	Co	12 Civilian Employee		Naval A		ıy	
P I	d oth	Be	17. Father's Name (First, Middla, Last)  18. Mothar's Name			,		
yla	Men Men arke	ို	Robert Lee Duvall Mary	Joseph	ine Moss	S		
Maryland	2 sh end la m		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural	Routa Numbe	r, City or Town,	State, Zip C	code)	
6,1	Heelth		Frances S. Duvall (Wife) 1007 Moss Haven Court A	nnapol	is, Mary	land	21403	
ŏ	If he or of or of		1 ☐ Burial 2 ☑ Cramation 3 ☐ Removal from State cematery, cramatory or other place)	3.4				
Baltimore,	t. Pertant:		4 Donation 5 Other (Specify) Ft. Lincoln Crematory July					
Ba	Depe Impo any la		21. Signature of Fuseral Service Licenses  22. Name and Addrass of Facility John 147 Duke of Glouces	M. Tay	lor Fune	eral H	Home, Inc. MD 21401	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory ar	rest,	1	approximate nterval Between	
	Physician /Medical		Immediate Cause (Final			†	Onset and Death	
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ó	icete be executed physician end s the buriel-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury				. Syears	-
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89	tifice ag ph es th	_	resulting in death) Last  d. Chronic Atrial Fibrillation			i	lyear	
ŏ	th cer	any	d. CHANCE MICHAELLAND			1	7047	_
E	dea he et ed fo	SICI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did t	obacco uae con	tributa to t	he cause of death?	
<u>o</u> .	thet the death cert ed by the ettendin deteched for use	Physician/M	Charles C. K.	10D	res 2 No	3 Probe	bly 4 Unknown	1
Ś	igner be d	þ	Chronil smoleting					
Division of Vital Records, P.O. Box	The law requires that the death certificate be executed ate has been signed by the ettending physician end page 2 should be deteched for use as the buriel-transit	Completed	Chronic Smoking  Recent Left hip fracture		an autopsy med?	com	autopsy findings able prior to pletion of cause ath?	
<u> </u>	The late he page	E O		1 🗆 Y	as 2000	10	Yas 2□ No	
ita	stan: otor,	Be (	25. Was case referred to medical examiner?	(Check only o	ne)			
<u> </u>	hysic nis ce	2	1 Yas 200No Hospital: 1 Inpatient 2 DER/Outpatient 3 DOA Other: 4 Nursing Hom	a 5 ☐ Rasid	ence 6 Othe	r (Specify)		
_	ng Pi		27. Manner of Death 28a. Data of Injury 1. Spatural 5 □ Pending (Month, Day Year) 28b. Time of linjury at Vork? 28c. Injury at Vork?	8d. Describe h	ow injury occurr	ed		
Sio	eath. or: A	catl	2 Accident Investigation M 1 Yas 2 No					
$\geq$	fter d fter d linect in by	Certification:	28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (S City or Tow	itreet and Numbern, State)	er or Rural I	Route Number,	
	pital praise miled		200 Codifice					_
	To the Hospital or Attending Physician: The law within 24 burus effectedath.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one)  Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, at an and manner stated.  To the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d at the time, o	ause(s) and mai date and place, a	nd due to t	ec. ne cause(s)	
	of the office of	Me	29b. Signature and the of certifier 29c. Licansa number	2	29d. Date signed	(Month, Da	ay, Yaar)	
	F>F0		MIN P mo D32654		July	1 19	97	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		04.9	) ''	, ,	-
				7010	mo al	012		
	Sta		31. Date filed (Month, Day, Year). 32. Registrar's Signature	,				

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 2 | 265

					Cert	tificate	e of	Death		R	eg. No.		
	Physic	an	Decedant's Nama (First, Middla, Last)							2. Data of Daa	th	Yaar	3. Tima of Death
	/Medi	cal	Raymond W. Dixon								25 1997		apprx 1:28 PM
A	Examir	ner	4e. Facility Name (If not institution, give straat and num 201 St. Mark Way, Apt.					4b. City, To		cation of Daeth	4c. County	of Deeth	Carroll
	Funeral Director		5. Social Sacurity Number 6. Sax 1 1 1 M M 2 □ F	7. Aga (In yrs. last bi	irthday) Yrs.	If Undar Months	1 Year Days	If Undar		8. Date of Birth (Month, Day	), Year) 7, 1915	9. Birthp Cour	place (State or Foraign htry) Maryland
	Maryland f show ed at	ō	Usual Rasidanca of Dacedant  10a. Steta 10b. County  MD Carroll	10c. City, Tow	_							1	0d. Insida City Llmits
	with the Rad or 28a-	I Director	10e. Street end Numbar 201 St. Mark Way, Apt.	<b>‡</b> 206		10f. Zip	Coda		21158		Og. Citizan of V		
0020	within 72 hours after death with the Maryland ilene. I then "netural", or Nerne 23a or 28a-f show the Medical Examiner must be notified at	d by Funeral	11. Manital Status  1 Nevar Marriad 2 M Married  3 Widowad 4 Divorced  12. Was Dace Armyed For 1 M Yas If Yas, Giv. Yaar or Da	2 □ No	lf '	as Dacedo Yas, speci □ Yas 2	ify Cub	an, Maxican	gin? (Spe , Puarto I		Specif	ck, Whita,	white
Maryland 21215-0020	C * 40	Completed	15. Decedant's Education (Spacify only highast greda complated)  Elementery/Secondary (0-12)  College (1-		(Giva kı lifa. Di	int's Usual ind of worl O NOT use <b>ounta</b>	k dona a ratire	during most	t of workii	ng	16b. Kind of B		ounting
br	should be filed withind Mentel Hygiene. marked other than imatic event, the M	Be C	17. Fathar's Nema (First, Middla, Last)				-	18. Motha	r's Nama	(First, Middle, I	Maidan Suman		
ylar	should by	TOE	Raymond W. Dixon					į.	Aimee	Wilson	n		
	d 2 th er		19a. Informent's Na <i>me</i> /Relationship ( <i>Type, Print</i> ) Helen W. Dixon, wife	19						#206,			Coda) , MD 21158
altimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20e. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from S 4 ☐ Donation 5 ☐ Other (Spacify)	tata	ary, crama	atory or of	har ple	ca) (Cemeto	06/27 ery	7/97	20c. Location - White		
Balt	permit. Departimonts any inj		21. Signatura of Funeral Sarvice Licensee		22.					ome & Cl		r, MI	)
	Physician /Medical Examiner		23a. Part1. Entar tha disaasa, or complications that ca shook, or haart failure. List only ona causa on as Immediate Ceusa (Final disaasa or condition rasulting in death)	used the death. Do ch line.  CUVVEN  Due to (or as a							ast,		Approximata Interval Batween Onsat and Death
ox 68760,	eath certificete be executed attending physicien end for use as the buriel-transit	in/Medical Examiner	Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Ceusa (Disaasa or injury that initieted evants resulting in daath) Last	Due to (or as a	consequ	ance of):							0
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Vital Records,	aw requires ts been sign 2 should be	Completed by								24a. Was a perform	n autopsy med?	av co	ara autopsy findings ailable prior to mplation of ceuse death?
E B	The ete h page	Соп								1 □ Y	as 2000	10	Yas 2 No
VIII.	Physician: T this certificer ral director, p	Be	25. Was case referred to medical axeminar?  Hospital: Hospital:				Ott	har		(Check only or	(a)		
Division of	Jing After fune	Certification: To	27. Manner of Deeth  1  Natural 5 Pending 2 Accidant invastigation		Time of Injury	М	Bc. Inju Wo	4□ Nu	No	28d. Describe ho	raat and Numb	red	y) al Routa Number,
۵	To the Hospital or Attend within 24 hours after deatl To the Funeral Director: completely filled in by the	edical Cer	29a. Cartifiar (Check only	est of my knowlader	e. daath	Z Socurred a	t the ti	ma, data and	d placa, a	nd dua to the c	ause(s) and ms	annar as si	tatad. o tha ceusa(s)
	o the	Med	one) and manni 29b. Signature and tiple of ceptilies	it stated	//	-		se number			9d. Data signe		
	F 3 F 8		1 ( )	1/1			_	7940	<b>.</b>	1	June 2		
			30. Name and address of person who complified cayse	of death (light 23a)	(Type P	-	~ J		1		sure &		1771
			Dr. Alexander Bogdas	chewsky	i, 1	425	Li	bert	y Rd	., Syl	cesvil	le.	MD 21784
	Sta Registr	te ar	31. Data filed (Month, Day, Yaar) 32. Re	gistrat's Signatura	Cardal	6		*					



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Dunn CATHERINE June 20 4b. City, Town, or Location of Deeth 1997 5:00 AM 4e. Fecility Neme (If not institution, give street end number) 4c. County of Death Salsibury, MD Salisbury Center: Genesis Eldercare Wicomico If Under 1 Year If Under 24 Hrs. 8.
Months Deys Hours Min. 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Months 1 □ M 2 1 F 88 August 8,1908 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Wicomico Salisbury 1 GYes 2 □ No 10f. Zip Code 10g. Citizen of Whet Country? 822 E. Isabella Street 21801 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Maxicen, Puerto Ricen, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 √ Widowed 4 Divorced White 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Seamstress Shirt Factory 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) George A. Whayland Mary Green 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Sharon L. Warren/Great Niece 32716 Mt. Olive Rd., Salisbury, MD 21804 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Steta 1 ☐ Buriel 2 ☐ Crametion 3 ☐ Removel from State 6/24/97 4 ☐ Donetion 5 ☐ Other (Specify) Parsons Cemetery Salisbury, MD 22. Neme end Address of Fecility m0/05/ Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804 bompoor 23a. Part1. Enter the disease, or complications that around the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feitura. List only one cause on baco line. Approximete Intervei Between Onset end Death SRADY GARdest AND Chypotensions Due to (or as a consequence of): 23b. Did tobacco use contribute to the ceuee of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings eveileble prior to complation of ceuse of deeth? 24e. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☑ No

Physician /Medical Examiner Physician/Medical Examiner

and

attending physician

signed by the a

certificate has

this funeral

After

within 24 hours after death.

To the Funeral Director: Al
completely filled in by the fu

filled in by

or Attanding Physician:

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by

Completed

Be

9

Certification:

Medical

The law requires that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglena. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any hilury or other traumatic event, the Modical Examiner must be notified at other.

Baltimore, Maryland 21215-0020

Grace

10a. Stete

Director

Funeral

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Completed

Be

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Maryland

11. Maritel Stetus

10e. Street end Number

12

20e. Method of Disposition

214-10-8014

Sequentially list conditions, if eny, leeding to immediate causa. Enter Underlying Cause (Disaasa or Injury that initiated events resulting In deeth) Lest

29b. Signature end title of certifier

Immediete Ceuse (Final disease or condition resulting in deeth)

Part II. Other eignific	ant conditi	ons contributin	g to death I	out not resultin	g in tha underl	ying ceuse give	en in Pert
		- 00	ΔΔ.	27	-1		

26. Place of Deeth (Check only one)

25. Wes casa referred to medical exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Naturel 2 Accident 1 Yes 2 No 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 ☐ Could not be 3 Sulcida 28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicide

29c. License number

D 39813

29d. Date signed (Month, Dey, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date end plece, end due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at tha time, data and place, and dua to the causa(s) and mannar stated. 29a. Certifier (Check only one)

30. Nama and eddress of parson who completed ceusa of deeth (Item 23e) (Type, Print) 1104 Healthway Dr., Salisbury, MD 21804 Michael R. Atkins, M.D.

State Registrar

32. Registran's Signature Randall

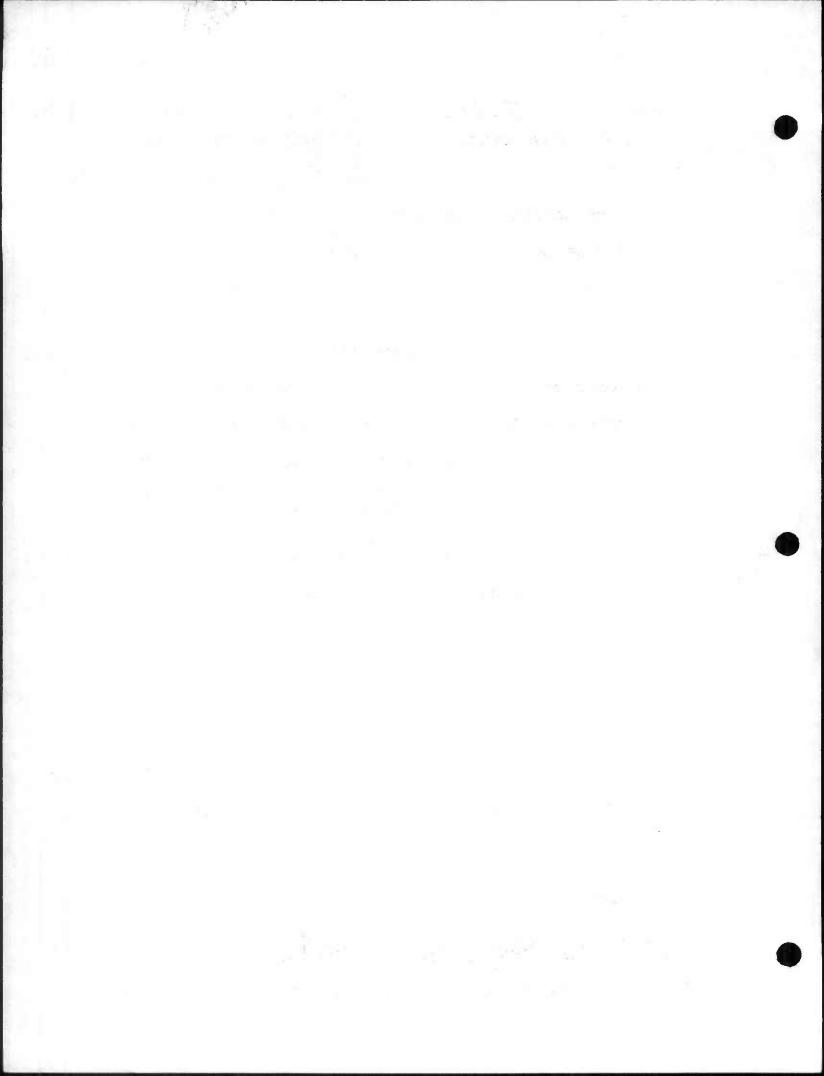
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State of Maryland / Department of Health and Mental Hygiene 97

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ľ	Physic	ian	Decedent's Neme (First, Middle, La.					1	2. Dete of De Month	eeth Dey	Yeer	3. Time o			
/Medic		cal	4e. Fecility Name (If not institution, giv	ECCI			4b. City, Town, or	June		997	02	340			
Examine			THE JOHNS HOPK		AT.			BALTIMORI		h 4c. County None	of Deeth				
	Funeral Director		Sociel Security Number     6. S		(In yrs. lest t		Inder 1 Year oths Deys	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De	th ey, Yeer)	9. Birthplece (State or Forei Country)				
	P.		Usuel Residence of Decedent 12/01/1946										Virginia		
nore, Maryland 21215-0020 ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. It of Health and Mental Hygiene. If item 27 is marked other than "netural", or items 23s or 28s-f show or other traumatic event, the Medical Examinar must be notified at	ctor	MD 10b. County Anne Art	ındel	Annapo	wn or Location Dlis	1				1	0d. Inside 0	City Limits s 2181 No			
	Funeral Director	10e. Street end Number 1327 Bay Head Ro	oad		10	f. Zip Code 21401			10g. Citizen of Whet Country? USA						
	by Fune	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E- Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			ecedent of I specify Cub	dispanic Orlgin? (Sen, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	Specify	k, White,	nericen Indien, nite, etc. white				
	Completed by	15. Decedent's Ec (Specify only highest gre Elementery/Secondary (0-12)	lucation de completed) College (1-4or 5+	.)		of work done OT use retire	petion during most of word d)	16b. Kind of B	usiness/Ind	dustry					
	ed w ygjen t, th	Co		Pı	residen	t/CEO		Retail Firearms Stor							
Maryland d 2 should be file th and Mental Hy 7 is marked othe traumatic event	should be filed with nd Mental Hygiene. marked other than umatic event, than	Be	17. Father's Neme (First, Middle, Last)			100			Name (First, Middle, Maiden Surnam			10)			
=	ould Mer Merke	5	Robert Lee Bryar	_				Marie H							
S	d 2 sho th and 7 is me traume		19a. Informent's Name/Relationship (			•		end Number or Ru				Code)			
	1 and 2 Health em 27 i		David Eccles (Hus 20a. Melhod of Disposition	spario)				d Road/An	napolis Date	20c. Location -		wn Stale			
Baltimore, bermit. Pages 1 al	t. Pa tmer tant:		1 Buriat 2 Temetion 3 Removal from State 4 Donetion 5 Other (Specify)  A Donetion 5 Other (Specify)  Cemetery, cremetory or other place)  Metropolitan Crematory 6/30								Alexandria VA				
n	Depar Impor any ir		21. Signature of Funeral Service Lifensee  22. Name and Address of Facility Advent Funeral & Cremation Service Annapolis MD 21401										s, Inc.		
		O.	23a. Pert1. Enter the disease, or compshock, or heart failure. List only	olications that ceuted to	he deeth. Do	not enter the	mode of dyi	ng, such es cerdiac	or respiretory e	rrest,		Approxime Intervel Be	te dween		
	Physician /Medical Examiner		Immediate Ceuse (Finel disease or condition resulting in death)	· Sub	Frack	noid	he	mmorth	Age		Onset end Deeth  4 days  5 days				
		ē					e of):		7						
	outed ansit	Examiner	Sequentially list conditions, Due to (or es e consequence or):  if eny, leading to immediate cause. Enter Undertying									43			
ć	icete be executed physician end s the burial-transit														
00/00	ysici he bu	Ical	Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest Due to (or es e consequence of):								-				
	n certifice anding pl use as t	/Mec	d												
POX	eath cert attendin I for use	cian													
5	that the de ed by the a deteched	Physician/Medical	Pert II. Other eignificent conditions of	ontributing to death but	not resulting	in the underly	ing cause giv	ven in Pert I.		23b. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Onknown					
necords,	law requires thet the death certificate be executed es been signed by the attending physician end a 2 should be deteched for use as the bunal-transit	Completed by							24e. Wes	en eutopsy ormed?	60	ere eutopsy eilable prior mpletion of	to		
ב	9 7 6	ошо							10	Yes 22 No		déeth? ]Yes 22	No		
Alla		Be	25. Was case referred to medical examiner?			26. Place of			eeth (Check only one)						
5	Physician: this certific ral director,	၉	1 ☐ Yes 2 ☑ No	Hospitel: Inpatient		Outpatient 3	DOA Oth	ner: 4 Nursing H	lome 5 Resi	dence 6 □Oth	er (Specif	y)			
	In a line	ë.	27. Manuer of Deeth  1 ☑ Naturel 5 ☐ Pending	28e. Dete of Injury (Month, Day	Time of Injury M	28c. Inju	rk?		how injury occur	red					
DIVISION	dea dea tor:	Certification:	Ž Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	Yes 2 No	28f. Location (Street and Number or Rural Route Number City or Town, Stete)										
2	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by		29a. Certifier (Check only   Medical Exam	ysician: To the best of	my knowledg	ge, death occu	rred et the til	me, dete and place	, and due to the	cause(s) end ma	inner es si	eted.	(0)		
	the H hin 24 the F	Medical	6	end manner state	ed.	niwoi investige			ired at the time,				(S)		
	V VIII	Σ	29b, Signature and title of certifier	60	0		29c. Licens	se number		29d. Date signe					
			Name and eddress of person who	completed cause of des	Mb (Item 22a	(Type Print)	40	09131		June :	29,	199	7		
			Keith A. Haitston	(200 Nuc+) 32. Registrer			ct Bo	itmore	MARULA	nd 21	287				
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrer	's Signeture	Pandell	2								

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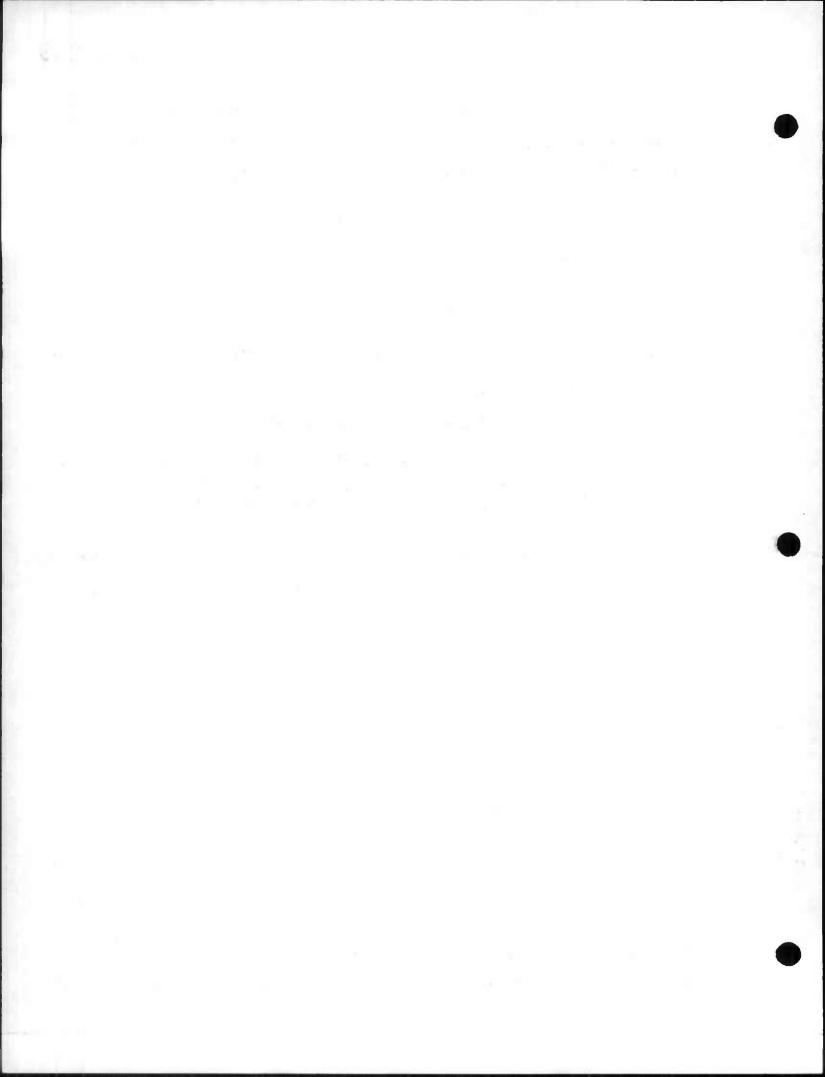
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				0	210 01 1110	ar y laria r		ificate of	Death	World 11	Reg. No.	1	21200				
Physician /Medical			1. Decedant's Neme (First, Midd		3,	E	= 57	EP		2. Date of D Month	Day	Year 1997	3. Tima of Death $3 : 35 pm$				
	Examir		4e. Facility Nama (If not institution						4b. City, Town, o	Location of Dea		4c. County of Death					
L			5825 Lakeview	41				If Undar 1 Yaar	Sykesv:		Carr						
	Funeral Director		5. Social Sacurity Number 220–36–7680	-7680 1 M 2 F 58 Yrs. Months Days Hou							Hrs. B. Date of Birth (Month, Day, Year) Feb. 27, 1939  Birthplaca (Stata or F Country)  Maryland						
	w #		Usual Rasidence of Decedant 10a. State 10b. Count	у		10c. City, To	own or Loca	ition					10d. Insida City Limits				
	the Maryler 28a-f show	tor	MD Ca	rroll				Sykesvi	ille			1 □ Yes 2 □ N					
	h the	irec	10e. Street and Number					10f. Zip Coda			10g. Citizan of	What Cou	ntry?				
	th wil	ai D	5825 Lakeview	Drive				217	784		U.S	S.A.					
21215-0020	ges 1 end 2 should be filed within 72 hours efter death with the Maryland to f Haelih and Mental Hyglena. If itam 27 ia marked other than "natural", or items 23a or 28a-f show or other traumatic svent, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 □ Nevar Married 2 ☒ Ma 3 □ Widowed 4 □ Divorce	rrled 1 [	If Yas, Giva			as Decedent of I leas, specify Cub		penic Origin? (Specify Yas or No- , Mexican, Puarto Rican, etc.) Specify:			can Indian, etc. ite				
5-0	72 hc	Completed	15. Deceda (Specify only high	nt's Education	platad)	16	Sa. Daceda (Giva kii	nt's Usual Occup nd of work dona	pation during most of weed)	orkina	16b. Kind of E	usinass/In	dustry				
121	vithin hen	mpi	Elementary/Secondary (0-12)		ollege (1-4or 5	+)		NOT usa ratire brariar		9	T - last						
Maryland 2	Hygle Hygle Ither t	ပိ	17. Father's Nama (First, Middle	Last)	3		ניד	nrarrar	_	ama (First Middle	Library na (First, Middle, Maidan Sumama)						
	id be ental ked o	To Be		ong						na Mitc		,					
ary	shou ind M i mar	-	19a. Informant's Name/Ralation	ship (Type, Pr	rint)	1:	9b. Mailing	Address (Straa	t and Number or F	Ru <i>ral Rou</i> ta Numi	ber, City or Town	, Stata, Zip	Coda)				
Baltimore, M			Mr. Howard M.	Estep	(Husba	and)	5825	Lakevie	w Drive	Sykesvi.	lle, MD	21784	1				
	permit. Pages 1 end Department of Haalth Important: if Itam 27 any injury or other ti once.		20a. Mathod of Disposition 1 ☐ Burial 2 ☑ Cramation 4 ☐ Donation 5 ☐ Other (3		al from Stata	cama	tary, crema	ion (Nama of tory or other pla Crematic	*	Data 6/30/9	20c. Location	-					
	permit. Pages 'Department of H important: If the any injury or of		21. Signature of Funaral Sarvice Licensaa  Address of Facility HAIGHT FUNERAL HOME & CHAPEL (Box 195)  Sykesville, MD 21784 (410)-795-1400									5)					
			23a. Part1. Enter the disease, or heart failure. Lie	r complication	s that caused	tha daath. D						400	Approximete				
	Physician		23a. Part1. Entar the disaasa, or complications that caused tha daath. Do not antar the mode of dying, such as cardiac or raspiratory arrast, shock, or haart fallura. List only ona cause on aach lina.									Intarval Between Onsat and Death					
П	/Medical Examiner												yeart				
ı	Lammer	_	Dua to (or as a consequence of):														
	nsit	Examiner		b				,				1					
,	axecu n and ial-tra	Exar	Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants			Due to (or as	a conseque	ence of):				į					
ς 68760,	The law requiras that the death certificata be axecuted ate has been signed by the ettanding physician and paga 2 should be detached for use es the bunat-transit	ledical	resulting in death) Last														
Box	thet the death cer ed by the ettandin detached for use	Physician/N		d													
	the e	ysic	Part II. Other aignificent conditi	ons contributi	ng to death bu	ut not rasulting	n tha und	arlying causa gi	ivan in Part I.	23b. Dlo	tobacco uaa co	ontributa t	o the cause of death?				
P.0	as thet the	/ Ph	1 Yes 20 N								Yes 20 No	3 Probably 4 Unknow					
Division of Vital Records,	w requiras been sign should be	Completed by								24a. Wa	s an autopsy formed?	av	ara autopsy findings vailable prior to empletion of ceusa daath?				
Re	sician: The law certificete has b lirector, paga 2 s	шо								1 🗆	Yas 22 No		□ Yas 2□ No				
ta	ian: 'rtifice	Be C	25. Was case rafarrad to medica	al					26. Place of De	eath (Check only	eath (Check only one)						
of V	hysic	To	axaminar? 1 ☐ Yas 2 ☑ No	Hospita	al: 1 🗆 Inpatia	nt 2 ERV	Outpatient	3□ DOA Ot	har: 4□ Nursing	Homa 5 Ras	sidance 6 Dot	har (Specit	fy)				
sion o	ending Pl sath. or: Aftar th	Certification:	27. Mannar of Death  1-CNatural 5 Pandi 2 Accident invast	Year) 28b	o. Tima of Injury	M 1	nyat ork? ]Yas 2 □ No	28d. Dascribe	28d. Dascribe how Injury occurred								
Divi	tal or Att rs eftar d ai Direct led in by	Certifi	3 Suicida 4 Homloide  Could not be determined  28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Spacify)  28f. Location (Straet and City or Town, Stata)									bar or Run	al Routa Number,				
	To the Hospital or Attending Physician: The I within 24 hours eftar death.  To the Funeral Director: Attar this certificete his completely filled in by the funaral director, paga	edicai	29a. Certifier 12 Certifyl (Check only one)	Exeminer: O	To the best on the basis of and manner sta	axamination (	ige, death o end/or inva	ocurred at tha ti stigation, in my	ime, date and plac opinion, death occ	e, and dua to the curred et tha tima	, data and place,	end due t	o the cause(s)				
	To To Con	2	29b. Signeture end titla of eartific	ee L	Inde	_	MD	29c. Licen:	3909		June	28	. 1997				
			30. Nama and address of persor Stephanie L	inder	ed causa of de	eath (Itam 23e	a) (Type, Pr	int) Ave	Baltim	ore, n	40 =	2122	24				
	Sta Registr		31. Dete filed (Month, Day, Yeer JUN 3	32 Registre	32 Aggistra's Signature												

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State of Maryland / Department of Health and Mental Hygiene 97 2126

			Certificate of Death Reg. No.													
			Decedent's Name (First, Middle, Last)											3. Time	e of Deeth	
	Physici /Medi		Gene S.				Month June 28	Dey 1997	Year	12:	15 P					
	Examir		4e. Fecility Neme (If not institution,						4b. City, Town		ation of Deeth	4c. County	of Deeth	2.4.		
1			Memorial Hosp	ital					Cumb	erla	nd	АТ	legan	īV		
1	Funerai				. Age (In yrs.	last birthdey)	If Under		If Under 24		B. Date of Birth (Month, Dey,			9	te or Foreig	חנ
	Director		233-40-9860	1 X M 2□ F	69	Yrs.	Months	Deys	Hours	Min.	Month, Day,	192 7	Coun	try)	miller	1
	ъ		Usuel Residenca of Decedent								CPI	111-1	~()/	0 / /	9100	4
how			10a. State 10b. County 10c. City, Town or Location											0d. Inside	City Limits	5
	e Ma	Ş	Maryland Alle	Jany	(	Lumb	opnia	7100	9					1 XY	es 2 N	D
	th th	Director	10e. Street and Number				10f. Zip	Code			10	g. Citizen of V	Whet Cour	ntry?		
	th wi	ai	904 Glen	1 wood	STIP	PT		21.	502			UST	7			
	dea	Funerai	11. Marital Status						lispenic Origi	n? (Spec	ify Yes or No- ican, etc.)		a - Americ			_
0	or ite	3	1 ☐ Never Married 2 ☐ Marrie	d 1 X Yes 2	2 □ No					Pueno H	can, etc.)		ck, White,	etc.		
9	ral'.	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dat	es: 1949-	-53	1 ☐ Yes 2	LA INO	Specify:			Specify	Bla	ck		
21215-0020	be filed within 72 hours after death with the Maryland tal Hygiena. Id other than "natural", or flems 23a or 28e-f show event, the Medical Examiner must be notified at	Completed	15. Decadent's	Education		16e. Dece	dent's Usual	Occup	etion	of working	10	6b. Kind of B	usiness/Inc	dustry		
7	an an an an an an an an an an an an an a	npie	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  Elementery/Secondary (0-12)  College (1-4or 5+)													
	or th	Con	12 Parking Garage AttendaNT Parkin									vg A	utho	rity	-	
nd	al Hy l oth	Be	17. Father's Name (First, Middle, La	ist)					18. Mother's	s Neme (	First, Middle, Ma	a <i>iden Suma</i> m	10)			
y a	should be filed nd Mental Hygi marked other imatic event, t	2	Clinton E	dmonsoi	V				Vi	ola	SPAN	cer				
Maryland	2 should be filed withi and Mental Hygiena. is marked other than eumatic event, the M		19a. Informent's Name/Relationship		1				end Number	or Rurel	Route Number,	City or Town,				
	is 1 and 2 should of Health and Mer item 27 is marke other treumatic		Priscilla Mon 20a. Method of Disposition	THOMPRY	SISTER	5906	504	, 7h	81-27	+ Pr	ive, To	ampo	, FI	19.3	3610	7
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	ПР	20b. P	laca of Dispo	osition (Nem	e of her plan	co) Rock	Ly . /	Date 20	c. Location -	City or To	wn, State		
Ĕ	Page nant o int: If i		4 □ Donation 5 □ Other (Spe		Vol	TORON	CAMO	700	v-600	1/	1007 (	umbe	orlan	vd. 1	nd.	
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signeture of Funerel Service Lie	censee	4	22	2. Name end	Addre	ss of Facility	7	1 22	- B-	14.	-//-	N.	
m	Dep du de de de de de de de de de de de de de		21. Signeture of Funeral Service Licensee  22. Name and Address of Facility  Leggure - Stein, Inc. 230 Boltimore Ave.  Combenied Md. 21502													-
	100				/	n. Do not ent	ter the mode	of dyir	ng, such es ca	ardiac or	respiretory erres	5 0 2 st.		Approxim	nate	-
	Physician		23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line.  Approximate Intervel Between Onset end Death													
	/Medical		Immediate Cause (Fine)												_	
	Examiner		disease or condition resulting in deeth)  Acute respiratory failure  Due to (or as e consequence of):  June 24,97												/	
		Je		Non C					. C. 1				1	D	1000	
	The law requires that the death certificate be axecuted at has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	Sequentially list conditions	b. NOII-5	mall c	ett ca		ma (	or rung	g				Dec.	1992	
o,	axe an ar rial-t		Sequentially list conditions, if eny, leading to immediate cause. Enter Undertying													
68760,	ysicii	Medical	cause. Enter Underlying Ceuse (Disease or injury thet initieted events	C	Due to (or	es e conseq	uence of):									
	entifica ding ph se as th	Jed	resulting in death) Last		,		,,						İ			
Box	eath cer attandin i for use	N/UE		d									<u> </u>			
	deat e att	Physician	Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.								23b. Did tobacco use contribute to the cause of death?					12
P.0	t the de by the a tached	hy									1 ∑Yes 2 □ No 3 □ Probably 4 □ Unknow					
S, F	as that igned b	by F									,,,,,,,			,		
rd	v requira been sig should t										24a. Wes en		24b. We	ere eutops eilable pric	sy findings	
Record	law requias been 2 shoul	Completed									performe	907	cor	mpletion o	of cause	
R	The la ata ha page	E O									1 □ Vec	2 No		Yes 2	□ No	
Vital		0	25. Wes case referred to medical						26 Place o	f Dooth /	Check only one			J 103 Z		-
>	Physician: this certific ral director,	0	exeminer? 1 ☐ Yes 2 ☑ No	Hospital:	nationt 2 🗆 I	ER/Outpatier	nt 3 DO	Oth	or.		5 Residen		or (Consis	4)		
of	Phy or this aral	Lä	27. Menner of Deeth	28e. Dete of	Injury	28b. Time of		-			d. Describe how			")		
lo	th. : After e funat	tio	27. Menner of Deeth 1. Maturel 5   Pending 2   Accident 3   Suicide 4   Homicide  28e. Dete of Injury 28b. Time of Injury 4 Work? 1   Yes 2   No  28e. Dete of Injury 28b. Time of Injury 4 Work? 1   Yes 2   No  28e. Dete of Injury 2 28d. Describe how Injury occurred  28d. Describe how Injury occurred  28d. Describe how Injury occurred  28d. Describe how Injury occurred  28d. Describe how Injury occurred  28d. Describe how Injury occurred  28d. Describe how Injury occurred  28d. Describe how Injury occurred  28d. Describe how Injury occurred  28d. Describe how Injury occurred  28d. Describe how Injury occurred  28d. Describe how Injury occurred  28d. Describe how Injury occurred													
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	e Hospital or At 24 hours after of 5 Funeral Direct tetely filled in by	<u>a</u>	29a. Certifier 1  ☐ Certifying	Phyelclan: To the b	est of my knov	viedge, death	n occurred e	t the tir	ne, date end i	place, en	d due to the ceu	se(s) end me	nner es st	eted.		
	To the Hospital or within 24 hours after To the Funeral Dirt completely filled in	edicai	(Check only 2 Medical Ex	aminer: On the bas end menne	is of examineti	ion end/or Inv	vestigation,	In my o	pinion, death	occurred	et the time, det	e end placa,	end due to	the ceuse	9(s)	
	To the within 2 To the comple	M	29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year)										)			
			KI)	-10	~ I	11)	1	) 2	2337	1	Ju	ne 30	1997	7		
	4		30. Name and eddress of person wh	o completed cause	of deeth (Item	23e) (Type	Print)			*						
	mel		Qamar Zamo					200	. (1)	us la	onlaus	1 m	1 -	10	03	
	Sta	te	31. Date filed (Month, Dey, Year)		gistrer's Signat		v / / /		,	( 6)7	1.142	1		-/ -/ '		
			OUT IT INCID	Charles Bloom												



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Yeer June 23, THOMAS 1997 ELLIOTT 1440 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Undar 24 Hrs. Hours Min. 7. Aga (In yrs. lest birthdey) If Undar 1 Yaar 8. Data of Birth (Month, Dey, Year) Birthpleca (Steta or Foreign Country) Devs 1⊠M 2□F 84 September 11.1912 Maryland . 10c. City, Town or Location 10d. Inside City Limits Wicomico Salisbury 1 ☐ Yes 2 ☐ No 10f. Zip Coda 10g. Citizen of Whet Country? 1827 Mt. Hermon Road 21804 USA 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2X Merried 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WW II White 15. Decedent's Education (Specify only highest greda complated) 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Custodian Wicomico County Courthouse 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Elliott Ruth Wilson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) Mary E. Elliott/wife 1827 Mt. Hermon Rd., Salisbury, MD 21804 20b. Pleca of Disposition (Neme of cemetary, cramatory or other plece) 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 □ Removel from State Springhill Memory Gardens 6/26/97 4 ☐ Donation 5 ☐ Other (Specify) Hebron, MD of Funeral Service Licensee 22. Name and Address of Facility M01051 Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804 blompson 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or raspiratory arrast, shock, or heart feilure. List only one cause on each line. Approximeta Intervel Between Onset end Deeth Due to (or es e consequence of) Dua to (or as a consequenca of): Part If. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part f. 23b. Dfd tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of causa of death? 24e. Wes en eutopsy performed? 1 ☐ Yas > No 1 ☐ Yes 2 ☐ No. 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ■ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28e. Dete of Injury (Month, Day Year) 28b. Time of fnjury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 TYes 2 TNo 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stefe) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, daath occurred et the time, dete end place, and dua to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and placa, end due to the cause(s) end menner stated.

requires that the deeth certificate be executed Box 68760 P.O. Division of Vital Records, or Attendin efter death. Director: Aft Hospital

Physician

/Medical

Examiner

**Funeral** 

Director

ir than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at

other

2 should be f end Mental H Is marked of

permit. Pages 1 end 2 sh Department of Heelth end Importunt: If item 27 is m

Physician

/Medical Examiner

physician end the buriel-transit

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should be deteched signed by

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certificate has

this funeral

director,

filled in

24 hours Funeral

ò any Injury once. þ

Completed

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2

Examiner

Physician/Medical

by

Completed

Be

10

Certification:

Medicai

filed within 72 hours after deeth with the Marylend

altimore, Maryland 21215-0020

JAMES

5. Social Security Number

214-10-6466

10e. Stete

Maryland

11. Marital Status

10e. Street end Number

5

Thomas

20e. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

Sequentielly list conditions, if eny, leeding to immadiate cause. Enter Underlying Ceuse (Disease or Injury that initiated events rasulting in death) Last

1 Nes 2 No

27. Manner of Deeth

2 Accident

3 ☐ Sulcida

4 Homlcide

(Check only one

29b. Signatura and title of certifian

9

Usuel Residence of Decedent

To the Hosp within 24 ho To the Fune completely fi 6+144

RONAGD 31. Dete filed (Month, Dey, Year)

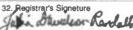
29e. Certifier

29c. Licensa number D36576 29d. Date signed (Month, Dey, Year)

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

RIVERSIDE DE SACISBURY MO 2180 560 (RAVITZ

JUN 26 1997



Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** Month AUGUST HENRY FLERLAGE 1997 12:30 AM /Medical 4e. Fecility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner PHYSICIANS MEMORIAL HOSPITAL LAPLATA CHARLES If Under 1 Yaar If Undar 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) XXM 2□ F Months Deys 51 Yrs. 217-42-8089 1945 Maryland Usuei Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes & ☐ No Directo St. Mary's Maryland Mechanicsville 10e. Streat and Number 10f. Zip Code 10g. Citizen of Whet Country? 27040 Oxley Drive 20659 USA Funeral 12. Wes Decedent Ever In U,S. Armad Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Bleck, Whita, atc. 11. Maritel Status 1 ☐ Yes 2 ☐ No If Yes, Give 1√ Never Married 2 Married 1 ☐ Yas 2 € No Specify: White À 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Worker Pepco 11 17. Fether's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Herman Aloysius Flerlage Gertrude Goldsmith 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Raietionship (Type, Print) 14790 Country View Place, Waldorf, MD 20601 Anthony G. Flerlage-Brother 20b. Plece of Disposition (Name of cematary, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Buriel 2 Cremation 3 Removel from State St. Mary's Cemetery 7-7-97 Bryantown, MD 4 Donetion 5 Dother (Specify) 21. Signeture of Funeral Service Licensee — Shannon W. Ramirez M00798 22. Nama and Addrass of Fecility Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604-0156 23e. Pert1. Entar the diseese, or complications that caused the daath. Do not anter tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart fellure. List only one cause on each line. Approximata Intervel Between Onset end Death ic Encephalopain Immediata Cause (Finel disaasa or condition resulting in death) Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Dua to (or as a consequence of) Due to (or as a consaquance of) RRHOSIS OF Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Ď 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24e. Wes an autopsy performed? 1 ☐ Yas 2 ☐ No Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) 1 Yes 20 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28c. Injury et Work? 28b. Tima of 26d. Describe how injury occurred Medical Certification: 5 Pending investigation 1X Naturei 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner as steted.

| Medicat Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner steted. 29a. Certifier 29b. Signeture and title of certifian 29c. License number 29d. Date signed (Month, Dey, Year) ule D-20310 30. Name and eddress of person tho completed cause of deeth (Item 23a) (Type, Print) SEETARAMAYYA NAGULA M.D. 11340 PEMBROOKE SQUARE SUTTE 202 WALDORF MD.

State Registrar

**Funeral** 

Director

or usin: it taim z/ is marked other than "natural", or liems 23s or 28s-f show. Injury or other traumatic event, the Modical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours aftar. Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or ites any Injury or other traumatic event.

Physician

/Medical

**Examiner** 

attending physician and for use as the burial-transit

signed by the a

page 2 s certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, to

The law requires that the death certificate be axecuted

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

death with the Maryland

31. Dete filed (Month, Dey, Yeer) JUL 0 3 1997

32. Registrar's Signeture

State of Maryland / Department of Health and Mental Hygiene Q7 21272

						Ce	rtificate of	Death			Reg. No.	1 6	212	16
ı	Physic	ian	Decedent's Name (First, Middle, Last							2. Date of De Month		Year	3. Time	of Death
J	/Medi		Walter W.	Galer						June 2	8, 1997	1001	7:00	) A.M.
ı	Exami	ner	4a. Facility Name (If not institution, give 4201 54th Street	street and number	)					cation of Daath	,			
L			5. Social Security Number 6. So	0V 7 A	ma //m .ma /aat/	h indh da sa	If Undar 1 Yaa	Blade r If Under		-	Prince			
	Funeral Director			0XM 2□ F	ge (In yrs. last I	Yrs.	Months Days	Hours	Min.	8. Date of Bird (Month, Da February	th y, <i>Year)</i> / 24 <b>,</b> 1914		place (State htry) sachuse	etts
	ylend		10a. State 10b. County		10c. City, To							10	0d. Insida	City Limits
	a-f s	ctor	Maryland Prince (	George's	Blad	ensb	urg						1 <b>X</b> □ Ye	s 2 No
	within 72 hours after death with the Marylend ene. than "natural", or items 23s or 28s-f show ha Medical Evarriner roust be notified at	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of ) United	What Coun	itry?	
	ath w	rai	4201 54th Street					710			of Ame			
	items items	Funerai	11. Marital Status	12. Was Decedent Armad Forces: 1 Tes 2	?	13.	Was Decedent of If Yes, specify Cu	Hispanic Orleban, Mexican	gin? (Spe i, Puarto i	cify Yes or No Rican, etc.)	14. Rac Blac	e - Americ ck, White, o		
020	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Yaar or Dates:	NO		1 ☐ Yes 2 ☐XNo	Specify:			Specify	Whi	to	
Maryland 21215-0020	72 hours "natural",	ted	15. Decedent's Ed	ucation	16	a. Dece	dent's Usual Occi	pation			16b. Kind of B			
21	d within 7 liene. r than 'n	Completed	(Specify only highest grad	College (1-4or	5+)		kind of work done DO NOT use retir	-	of workir	ng				
12	77 12 14 15	Co	10	-32-3-110		Own	er/ Oper				Plumbir			
and	be fill d out	Be	17. Father's Nama <i>(First, Middi</i> e, <i>Last)</i> Walter Galenski								Maidan Sumam	ie)		
Ž	should be that marked of umatic even	Lo		(%-i-A)			111			alensk:				
			19a. Informant's Name/Relationship (7) Patsy Johnson/ Da				ng Address (Stree Box 193					State, Zip	Code)	
re,	of Health itam 27 i		20a. Method of Disposition		20b. Place		osition (Nama of matory or other pla			Date	20c. Location -	City or To	wn, Stata	
E	ant ol nt: If i		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				m <i>atory or othar pl</i> islaus Ceme			uly 1, 1997	South I	eerf:	ield,	
Baltimore,	permit. Pages 1 Depertment of H important: if its any injury or ot once.		21. Signature of Funaral Sarvice Licens			22	2. Nama and Addr	ess of Facilit	У		Massac	nuse	LLS	
Ω	S S II S		Kourudi	A Can	2000		risley F 07 Sugar				th Deerf	-1011	MΛ	01272
			23a. Part1. Enter the disease, or comp shock, or heert failure. List only of			not ent	ter the mode of dy	ing, such as	cardiac o	r raspiratory ar	rest,	Teld	Approxima	ata
	Physician			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,									Onset and	J Deeth
	/Medical Examiner		immediate Cause (Final disease or condition resulting in death)	_ Carcin	oma of	Lun	g With M	etasta	ses			Ì	3 Mo	nths
В		<u>-</u>	resulting in death)		Due to (or as a	a consec	quence of):					Ì		
	uted d ansit	Examiner		b. ————	Due to force		, ,							
ó	ntificete be executed ng physician end es the buriel-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a	a consec	quence of):							
68760,	ste be nysicia	Medicai	Cause (Disease or injury that initiated events rasulting in death) Last	c	Due to (or as a	conseq	juence of):							
	and and and		25.000	٠								į		
Вох	as thet the daath certific: igned by the attending pl be detached for use es i	Physician/		d										
P.O.	0 0	ysic	Part II. Other significant conditions co	ntributing to death b	ut not resulting	in the u	nderlying ceuse g	iven In Part I.		23b. Did t	obacco use co	itribute to	the cause	of death?
	thet t led by deta	y Ph	Congestive Heart	Failure						1 🔃	Yes 2 No	3 Prob	abiy 4	Unknown
Division of Vital Records,	The law requiras thet the ate has been signed by th page 2 should be detache	d by	Coronary Artory D	danaa						24a. Was	an autopsy		ere autopsy	
00	w require s been si	Completed	Coronary Artery D							perfo	rmed?	con	ailable prior mpletion of death?	to
æ	The la	mo:								101	ras 2⊠No		Yes 2	□No
ita	ician: The certificate rector, pag	Bec	25. Wes cese referred to medicel examiner?					26. Place	of Death	(Check only o				
5	Physic this ce	2	1 ☐ Yes 2XXNo	Hospital: 1 Inpatie			IL SEL DOA		rsing Horr	ne 5 🗓 Resid	ience 6 DOth	er (Specify	")	
U.	ling P	ion:	27. Manner of Death 1 ☑Naturel 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b.	Time of Injury	Wo			8d. Describe h	now injury occurr	ed		
S	or Attending Physician: efter death. <b>Director:</b> After this certifical i in by the funerel director,	Icat	2 Accident Investigation 3 Suicide 6 Could not be	29a Place of Ini	un. At home if	form etr	1474	Yes 2 N		9f Location /6	Street and Numb	or or Dum	I Pouto Nu	mhar
<u>S</u>	or A effer Direct	Certification:	4 Homicide determined	building, et	c. (Specify)	rarm, str	aet, factory, office		-	City or Tow		er or murar	Houte /vui	n <i>oer</i> ,
	spita hours neral y fille		29a. Certifier 1 Certifying Phy	sician: To the best	of my knowledg	e, death	occurred at the ti	ime, date and	place, a	nd due to the o	cause(s) and ma	nner as str	ated.	
	To the Hospital or Attending Physician: The law within 24 hours effected alth.  To the Furneral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	(Check only 2 ☐ Medical Exami one)	ner: On the basis of and mannar sta	examination a	nd/or Inv	vestigation, In my	opinion, deat	h occurre	d at tha time, o	date and place,	and dua to	the cause	(s)
	To the within 2 To the comple	Σ	29b. Signature and title of pertiller	0	- >		29c, Lican	se number		-	29d. Date signed	(Month, E	Day, Yaar)	-
			10	non	77	_	D14	4799			June	30, 1	.997	
			30. Name and address of person who-ed					li «	100	D.1			1 05	
			k. Joseph Matthew 31. Data filed (Month, Day, Year)			11TW	orth Ave	nue #1	400,	Riverd	lale, Ma	rylan	ıd 20	/37
	Sta Registr	-	50		ar's Signature	n								
DHE	WH 16 Rev 6/95		JUL 0 3 1997	guia	levide-	Montan								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Deeth GOODMAN 1997 JUNE 13:55 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth BALTIMORE CITY CITY THE JOHNS HOPKINS HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, JULY 13 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Months Days Hours 1 ☐ M 2 ☑ F MARYLAND Yrs 39

> 10d. Inside City Limits 1X Yes 2 No

BLACK

**Funeral** Director

**Physician** 

/Medical

Examiner

KAREN

212-70-6728 Usuel Residence of Decedent

The law requires that the death certificate be executed physician end s the burial-transit Division of Vital Records, P.O. Box 68760, ettending pl signed by the e certificate has b Hospital or Attending Physician: this efter deetl Director: filled in by To the Hospital of within 24 hours of To the Funeral D completely filled

Peges 1 and 2 should be filed within 72 hours efter death with the Menyland net of Health and Mentel Hyglene. Intil If Item 27 Is marked other than "natural", or Items 23a or 28a-f show mix if Item 27 Is marked other than "natural", or Items 23a or 28a-f show my or other traumatic event, the Medical Exercities are notified at my or other traumatic event, the Medical Exercities are 10a Stete 10b. County 10c. City, Town or Location Directo MARYLAND ANNE ARUNDEL ARNOLD 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 792 MATCH POINT ROAD 21012 US Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever In U,S. Armed Forces? Race - American Indian, Bleck, White, etc. 1 Never Married XX Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) CARR LOWREY GLASS CO. College (1-4or 5+) 12th PACKER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BERNARD W. CLEMONS HAZEL GRIFFIN 2 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) DOUGLAS GOODMAN (HUSBAND) 792 MATCH POINT RD. ARNOLD, MD. 21012 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State permit. Peges
Department of
Important: If It
any Injury or o 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State ARBUTUS MEM. PARK 7/5/97 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenses 22. Name end Address of Facility
WM. REESE & SONS MORTUARY, P.A. Dege 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failufe. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) RESPIRATORY DISTRESS Examiner Due to (or es e consequence of): Examiner LYMPHOMA Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 24a. Was en eutopsy performed? 1 Yes 2 No Be 25. Was cese referred to medical exeminer? 26. Plece of Death (Check only one) Hospitel: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA

821 WEST ST. ANNAPOLIS, MD. 21401 Approximete Intervel Between Onset and Death 3 SYNDROME WESILS 1.5 YLAUS 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1 ☐ Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) Certification: To 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edicai 29a. Certifier Ecrtifying Phyelcien: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated. 29d. Date signed (Month, Dey, Yeer) 29b. Signature end title of certifier 29c. License number 1297 Pho D46104 29 MA 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) BALTIMORE MA ROBERT ORLOWSKI WELPS 600 ~ . 2128 31. Date filed (Month, Dey, Year) 32. Pegistrar's Signature JUL 07 1997

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Annie Grant June 22 1997 1:30 PM /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Genesis ElderCare -The Pines Easton Talbot If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) **Funeral** Deys 1□M 20 F Months Hours Yrs. Director June 2, 1914 South Carolina 255-64-5103 Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Caroline Preston 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 22030 Marsh Creek Road 21655 USA Funeral Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 à Specify: 3 Widowed 4 □ Divorced Yeer or Detes: Black Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8th Laborer Labor other 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) permit. Pages 1 and 2 should be.
Department of Health and Mertal Important: If Item 27 is marked ott any Injury or other treumers. Be Unknown Unknown 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Virginia Sharp (friend) 22030 Marsh Creek Rd., Preston, Maryland 21655 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Mt. Pleasant Cemetery 6/28/97 Preston, Maryland 21. Signature of Funeral Service Licansee 22. Name end Address of Fecility Bennie Smith funeral Home P.O.Box 1687, Easton, Maryland 21601 rence 23a Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, and or heart feilure. List only one cause on each line. Approximete tntervel Between Onset end Death Physician /Medical Immediete Ceuse (Final disease or condition resulting in deeth) ereprovascular accident Examiner Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. the 23b. Did tobacco uee contribute to the cause of death? been signed by 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No þ 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed has 1 Yes 2 No certificate 1 □ Yes 2 □ No or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 ☐ Yes 2 No Hospitel: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Certification: Natural 5 Pending Investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end placa, end due to the cause(s) end menner stated. edical 29a. Certifier (Check only one) 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) MICHAEL MD HVENDE CROWLE 508 IDEWIND

State Registrar 31. Dete filed (Month, Dey, Year)

32. Registrer's Signeture

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Yeer **GREENWOOD** 06 23 97 1120 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Daeth 822 SOUTH SHUMAKER DRIVE SALISBURY WICOMICO If Undar 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sax 1 M 2 □ F 7. Aga (In yrs. last birthdey). Birthplaca (Stata or Foreign Country) Days Yrs. Pennsylvania 53 09-02-43 10b. County 10c. City, Town or Location 10d. Insida City Limits ty Yas 2 No Wicomico Salisbury 10f. Zlp Coda 10g. Citizen of What Country? Schumaker Dr., Apt. 302 21804 USA 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Detes: Navy 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 XDivorced WHITE 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Healthcare Administrator 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Robert Charles Greenwood Barbara Jean Williams 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Jennifer L. Taylor/daughter 308 Main St., Watsontown, PA 17777 20b. Placa of Disposition (Neme of cematary, crematory or other piece) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 Cramation 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Salisbury Crematory 6/25/97 Salisbury, MD of Funeral Service Licensee 22. Nama and Address of Facility m01051 Holloway Funeral Home 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Salisbury, MD 21804 Approximate Intervel Between Onset end Death . ASPHYXIATION Due to (or as a consequenca of): DRUG INTOXICATION Due to (or as a consequence of): Dua to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of causa of deeth? 1 ☐ Yas 2 X No 25. Wes casa referred to medical 26. Placa of Death (Check only one) Other: 4 ☐ Nursing Home 5 🌠 Residenca 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dev Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner es steted.

Wedical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) end menner stated. 29b. Signeture and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year)

Examiner The law requires that the daath certificate be axecuted Records, P.O. Box 68760. Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director;

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

Be

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumstic svent, the Medical Examiner rivest be notified at

the Manylend

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filed within 72 hours efter Hygiana.

permit. Pages 1 and 2 should be filed within Department of Health end Mental Hygiena. Important: If Itan 27 is marked other than any Injury or other trainment.

**Physician** /Medical

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Certification:

Medical

Baltimore, Maryland 21215-0020

5. Social Security Number

549-60-9389

10e. Street end Number

822 S.

12

20e. Method of Disposition

Immediate Cause (Final

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieled avents resulting In deeth) Lest

1 Yes 2 No

27. Menner of Deeth

1 Neturel

2 Accident 3 Sulcide

4 ☐ Homicide

(Check only

31. Dete filed (Month, Day, Year)

29e. Certifier

disease or condition resulting in deeth)

21. Signature

10a, Stata

Maryland

SHIP

State Registrar

BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MD 21801 JUN 26 1997

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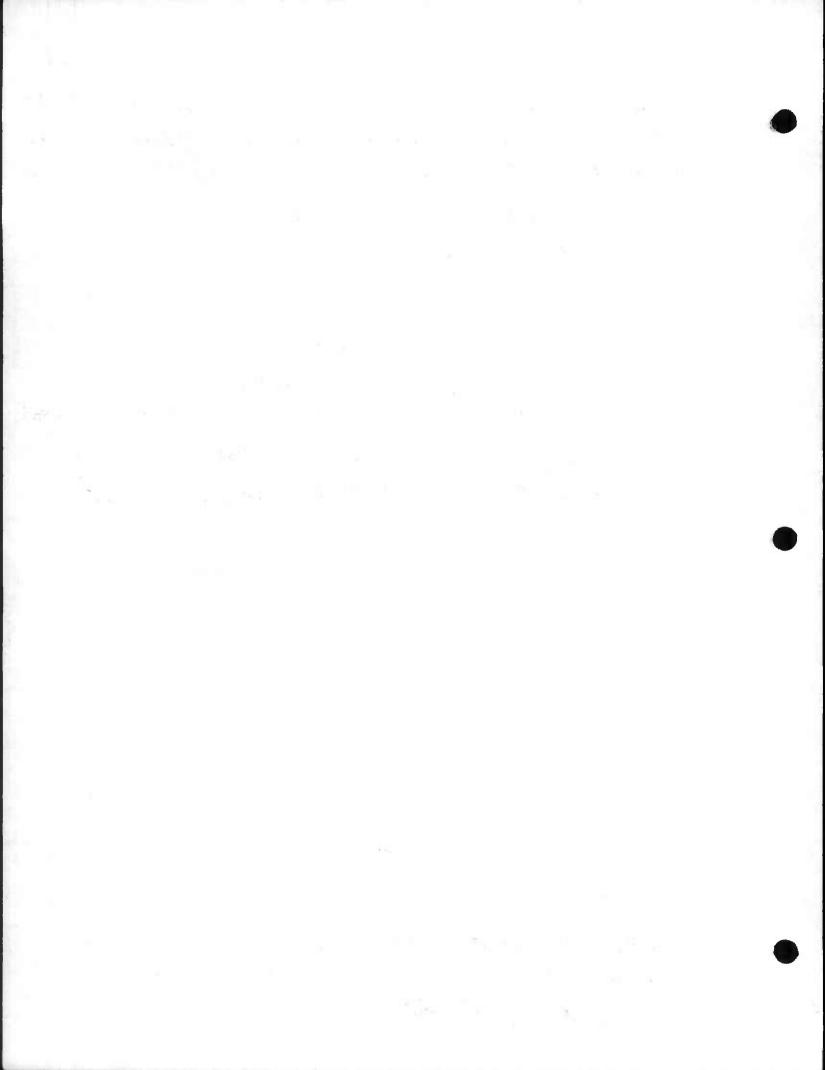
06-23-97

30. Name end/eddress of person who completed cause of deeth (Item 23e) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene

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			Certificate of Death	В	eg. No.	•	41410
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	Exami		4a. Facility Name (If not institution, give street end number) 4b. City, Town, or U	Location of Daath	4c. County	of Death	
				ipolis	Ann	e 44	eundel
	Funeral	1	5. Sociel Security Numbar 6. Sex 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. Months Days Hours Min.	8. Data of Birth (Month, Dey	Year)	9. Birthp	lece (State or Foreign
	Director		212-20-3/33	2-4	-20	Sout	h Co+6LINA
	pue *_		Usual Rasidence of Decedent  10e. Stete 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
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	the Marylen r 28e-f show	ect			0g. Citizen of \	Man Cour	
	deeth with the Marylend ms 23a or 28a-f show I must be notified at	Funeral Director	10e. Street and Number  10f. Zip Code  129 W. Earliegh Heights  21/46			SA	nry r
	ne 23	era	121 1. Cars of 1014113	pecify Yas or No-		e - Americ	an Indian
0		Fun	Armed Forces? It Yes, specify Cuben, Mexican, Puàrt	o Rican, atc.)		ck, White,	
21215-0020	hours efter ural', or its	ρ	3 ☐ Widowed 4 ☑ Divorcad It Yes, Give 1 ☐ Yes 2 ☑ No Specify: Yaar or Detes:		Specify	BL	ack
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Maryland	d 2 should be filed th end Mental Hygi 7 Is marked other traumatic event, I		19e. Informent's Name/Reletionship (Type, Print)  19b. Meiling Address (Street end Number or Ru	ıral Route Number	, City or Town,		
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ore	ges 1 end it of Health If Item 27 or other to		20a. Method of Disposition  20b. Plece of Disposition (Name of generatory, cramatory or other plece)	Pete	20c. Location -	City or To	wn, Stete
Baltimore,	0 E # >		4 Donation 5 Other (Specify) Hilcrest Memerial	13/97	Annap	12-15,	Md.
alt	permit. Per Depertmen Important: any injury once.		21. Signature of Funeral Service Licensee . 22. Name and Addrass of Facility	1 192	2 70	rest	SIR
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Box	v requires thet the deeth cer been signed by the attendir should be deteched for use	an	d				
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	5 1 kg		29b. Signature and title of certifier  29c. Licansa numbar	2	9d. Data signe	d (Month, )	Dey, Year)
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			Whymae My Attending Doctor D2 1684  30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)  CN-CYRIAC. M.D 8109 RITCHIR HWY, PAS	ADRNA	, mr	رو	123
			C-VICAKING III 8 107 A COME WOWI, POPPE		1 (1)	7/	
	Sta	-	31. Date tiled (Month, Day, Year)  32. Registrar's Signeture  11. 10. 3. 1997				
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State of Maryland / Department of Health and Mental Hygiene 97

				Cer	tificate of	Death	R	leg. No.		
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Phys /Me	ician dical	James Bernard I	Harley, Jr.				June	30 I	1997	11:40p.m
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Funer Directo	_	5. Social Security Number 6. Se 579-16-4518	7. Age (In yr	s. lest birthdey) Yrs.	If Under 1 Year Months Deys	Hours Min.	8. Date of Birth (Month, Dey SEPT. 2	, 1915	9. Birthpl Count MARY	lece (Stete or Foreign try) YLAND
and wo		10e. State 10b. County	10c. (	City, Town or Lo	cation				16	0d. inside City Limits
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r 28a	Director	10e. Street end Number			10f. Zip Code		1	0g. Citizen of \	Whet Coun	try?
h with	O E	9145 HAWTHORNE ROA	AD		2	20646		UNITED	STATE	-5
d 21215-0020 filed within 72 hours after death with the Maryland Hygiens then "natural", or items 23e or 28e-f show ont, the Medical Exemples must be notified at	by Funeral	11. Maritel Status  1 Never Merried 2 Merried  3 Ma Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give Year or Dates:		Ves Decedent of H Yes, specify Cube	lispenic Origin? (Spen, Mexican, Puerto Specify:		14. Rec	ce · America ck, White, o	an indien,
15-002 72 hours "netural",	8	15. Decedent's Edu		_	ent's Usuel Occup	pation		16b. Kind of B	INI usiness/ind	JIAN
d 21215-0020 filed within 72 hours af Hygiana. Ther then "netural", or ont, the Medical Experi	Completed	(Specify only highest grad Elementery/Secondery (0-12)	College (1-4or 5+)	(Give	kind of work done OO NOT use retired IENT OPER	during most of world)		STATE H	IIGHW/	AY
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Mar id 2 sho ith and it is me		JAMES A. HARLEY -				D, WALDOI				Code)
Haa Haa		20e. Method of Disposition		Plece of Dispos	sition (Neme of			20c. Location -		wn, Stete
Pagas ant of rt: If I		1 Buriai Cremation 3 □F 4 □ Donetion 5 □ Other (Specify)	Removal from State		ON CEMET	ERY, JULY	/ 5 100	7 CLTM	TON	MADVI AND
Baltimore, Miponemit. Pagas 1 and 2 Department of Health a Important: if from 27 is any injury or other trai	ei	21 Signature of Funday Service Licens	<b>a</b> e ()						IIUN,	MAKILAND
W Segra	a	MGB / YOU'C / A. I	M00053			UNERAL HO				
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ox 68760, n carificata be axecuted inding physician and use as the burial-fransit	edicai	thet initiated events resulting in deeth) Lest	Due to	(or es e consequ	uence of):				1	
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Division of Vital Records, P or Attending Physician: The law requires that after death.  Director: After this certificate has been signed to it by the funeral director, page 2 should be detail	Completed b						24e. Wes e	en autopsy med?	cor	ere eutopsy findings bileble prior to mpletion of cause deeth?
Tha is	Š						1 □ Y	es 20 No	1	Yes 2□ No
f Vital I yslcian: Th s certificata director, pag	Be	25. Wes case referred to medical examiner?				26. Place of Dee	th (Check only on	18)		
of Vita Physician: this certific ral director,	2	1 Yes 2 No	lospital: 1 Inpatient 2	ER/Outpetien		4 LI Noising H	ome 5 Reside	ence 6 🗆 Oth	er (Specify	)
Sion o tending Ph leath. for: After th the funeral	on:	27. Manner of Deeth  1 Anaturel 5 Pending	28a. Dete of Injury (Month, Day Year)	28b. Time of injury	28c. Injur Wor		28d. Describe h	ow injury occur	red	
Vision Attending Ir death. Octor: Afta	cat	2 Accident investigation 3 Suicide 6 Could not be	CO. Characterists			Yes 2 □ No	201 11 (0			18-1-11-1
Division  al or Attend s after death il Director: /	Certification:	4 Homicide determined	28e. Place of Injury · At building, etc. (Spec	home, farm, stre cify)	et, fectory, office		28f. Location (Si City or Town		er or Hura	Houte Number,
Divi To the Hospital or Att within 24 hours after of To the Funeral Direct compilately filled in by	edicai	29a. Certifier (Check only one) 1 Certifying Physical Examilia	sician: To the best of my kr ner: On the besis of exeminend menner steted.	nowledge, deeth netion end/or Inv	occurred et the tin estigation, in my o	ne, dete end plece, pinion, deeth occur	end due to the cred et the time, d	ause(s) end me ete end plece,	enner es st and due to	eted. the ceuse(s)
With To the	×	29b. Signeture end title of certifier	0		29c. Licens	e number	2	9d. Date signe	d (Month, L	Dey, Year)
		Kough	M. Md	Jhn	D28	352	J	uly 1	, 199	97
		30. Neme end eddress of person who co								
		Krishan Mathur	, M.D P	. O. Be	ox 2729	, La Pl	ata, MI	206	46	

Registrar

JUL 0 3 1997

Jalia Davidson Randall

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State of Maryland / Department of Health and Mental Hygiene 97

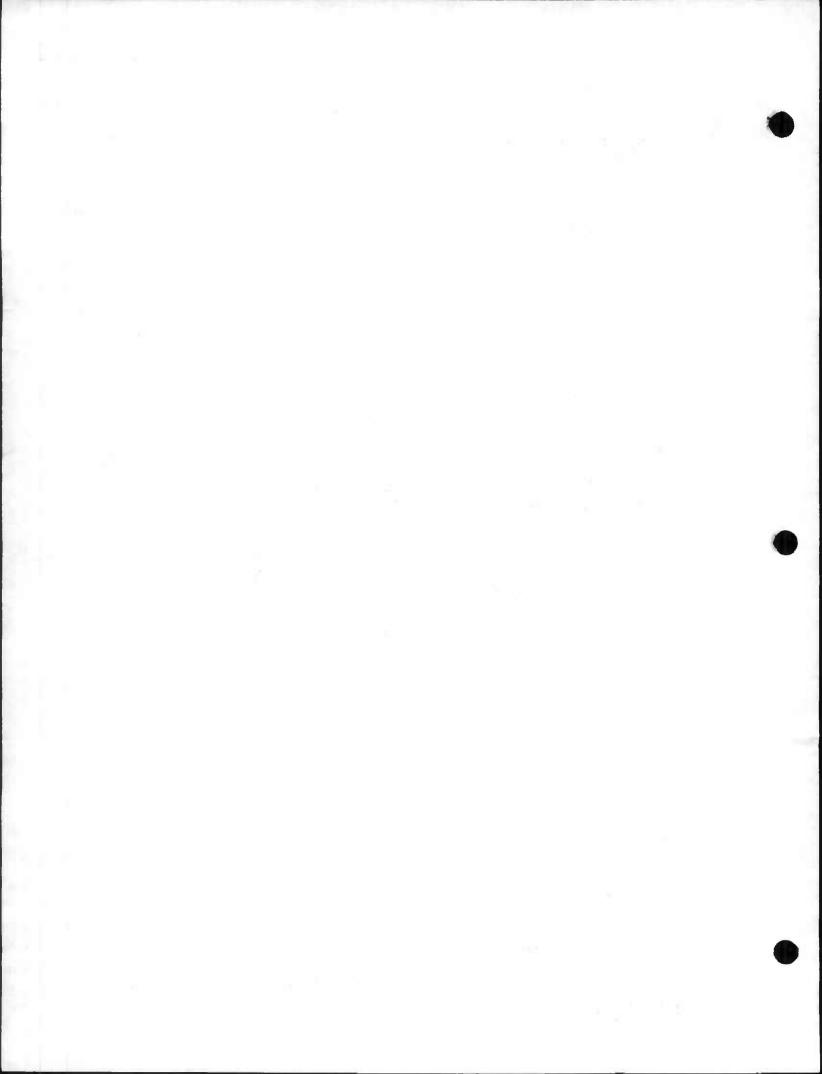
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Month Day 199<sup>Yeer</sup> June 26 2:59PM Harris Edward /Medical Steven 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Talbot The Memorial Hospital Easton 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex VX M 2□ F 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Yrs. Director Maryland 220-28-2110
Usual Residence of Decedent 01 - 20 - 3562 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be notified at Director 1 Yes 2 □ No Maryland Caroline
10e. Street end Number Greensboro 10f. Zip Code 10g. Citizen of Whet Country? 21639 Funeral USA 603 W. Sunset Ave. 12. Wes Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No KYĕs, Give Yeer or Dates: Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 end 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Itam 27 Is marked other than "natural", or Iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2.2 No Specify: þ Specify: 3 ₩idowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th Factory Laborer 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be James Morgan Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Depertment of Health ar Important: If itam 27 is any injury or other trau 309 Choptank Ave., Cambridge, Maryland 21613 Dill (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sandtown Cemetery 7/1/97 Hillsboro, Maryland 22. Name end Address of Fecility Bennie Smith Funeral Home I 1687, P.O.Box, Easton, Maryland 21601
Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, br heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) and my called of the interpretation of the contract of the con Examiner Physician/Medical Examiner physicien end the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet Initiated events resulting in deeth) Lest Due to (or as e consequence of): Box 68760. Due to (or es e consequence of): P.O. Part II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown on Mites, India Records, þ 24b. Were eutopsy findings eveileble prior to Completed 24a. Wes en eutopsy performed? completion of cause of deeth? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, to Be 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 □ Yes 2 □ No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 🗌 Pending 1 TYes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. Medical 29a. Certifier 29b. Signature end title of certifier 29d. Date signed (Month, Dey, Yeer) 29c. License number 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 510 S. 54 Ave, Denton, md. 21629 32. Registrar's Signature eli 31. Dete filed (Month, Day, Year) State

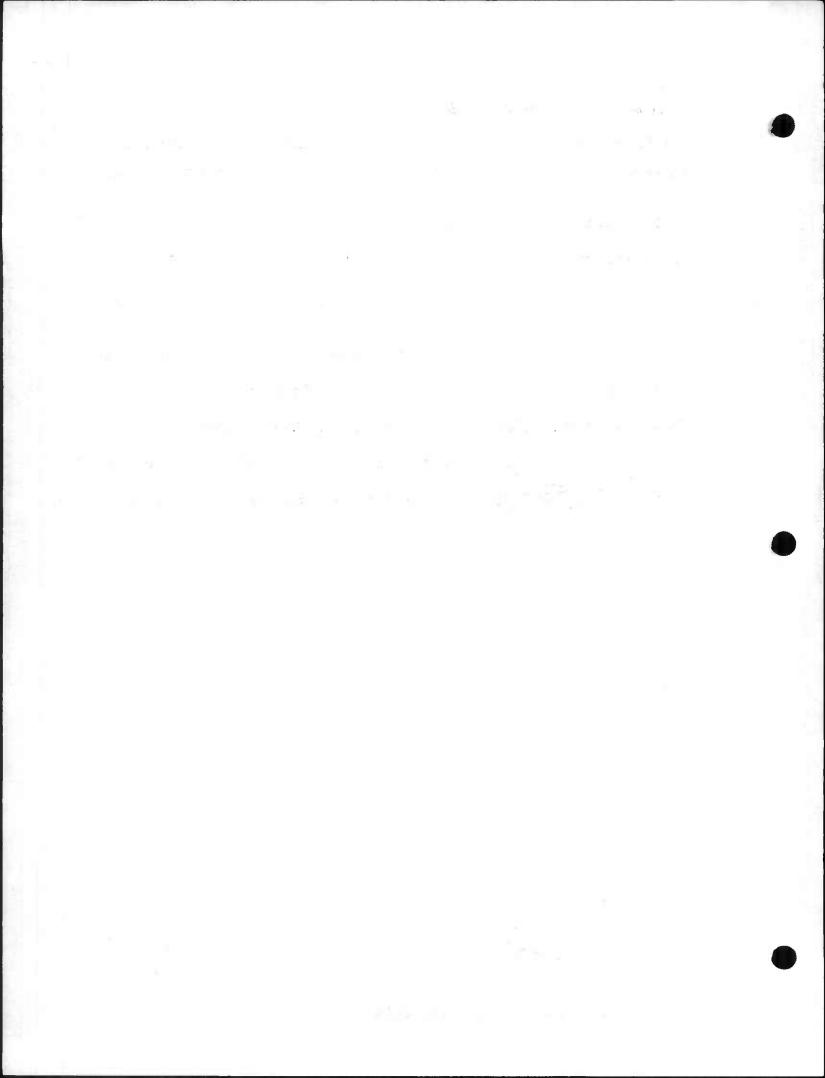
Registrar

7JUN 3 0 1997 >



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97

						Certifica	ate of	Death	R	eg. No.	,	(m 1 1	
	Physici /Medi		1. Decedant's Name (First, Middle, L.)	Hodg.	15				2. Deta of Daa Month		Yaar 97		of Death
	Examir		4a. Facility Neme (If not institution, gi	va street end numbar)			4	b. City, Town, or L	ocation of Death	4c. County	of Death		
			10602 Flower Street					Berlin		Worces	ter		
	Funeral Director		262-46-6708	Sax 7. Age	(In yrs. last birt	hday) If Und Month	der 1 Yaar is Deys	If Undar 24 Hrs. Hours Min.	8. Deta of Birth (Month, Day 10/7/19	Year)	9. Birthpl Count Georg		or Foreign
	pug *		Usuel Residance of Decedent  10a. State 10b. County		10c. City, Town	or Location					10	nd Ineide	City Limits
	Maryl fehic	ō	Maryland Worcester		Berlin						"		s 2 No
	28e	rec	10e. Street and Number		DELIIII	10f. 2	Zip Coda		1	0g. Citizan of \	What Coun	try?	
	3a or	Funeral Director	10602 Flower Street			- 1	1811			U.S.			
	death	Jera	11. Maritei Status	12. Wes Decedant E	var in U,S.			lispenic Origin? (Sp an, Maxican, Puerto	ecify Yes or No-	14. Rac	e - America		
Baltimore, Maryland 21215-0020	d 2 should be filed within 72 hours efter death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show traumetic event, the Medical Examinat must be notified at	by	1 ☐ Navar Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Give Yaar or Datas:			37	an, Maxican, Puerto Specify:	Rican, atc.)	Specify	ck, Whita, a		
5-0	72 ho	sted	15. Decedant's E (Specify only highast gr	ducation	16a.	Decedent's Us	suei Occup	ation	ina	16b. Kind of Bi	usiness/Ind	lustry	
21	ithin see	Completed	Elementery/Sacondary (0-12)	College (1-4or 5+	)			during most of work i)	ang .				
2	filed within Hygiene. Ither than " ent, the Me		6th			Damest	ic Wor			Damest:		ζ	
and	12 should be fi h and Mental I- is marked out raumatic ever	Be	17. Fether's Nema (First, Middle, Last	)				18. Mother's Nam		Maiden Sumen	10)		
Ž	should ind Men marke	10	George Adams	Transit Outon	405	A 4 - 100	(0)	Estella C					
Ma	nd 2 salth an 27 is r		19a. informant's Name/Relationship					end Number or Rui			State, Zip	Code)	
ē,	- 9 E E		Clarence V. DeLancey, 20a. Method of Disposition	Jr./Son	20b. Pleca of cameter)	DUZ FIOW Disposition (A	er Str Name of	eet Berlin,		21811 20c. Location -	City or To	wn. Stete	
no	00		1 Buriel 2 ☐ Cramation 3 E 4 ☐ Donation 5 ☐ Other (Speci										
1			21. Signeture Full Service Lie	/ //	Woodlaw			ss of Facility	/28/97	West Palr	n beacr	ı, el	
B	permit. Departri Importa any inju		OK	10		Lewis N	. Wats	on Funeral.			d., Sal	Lisbur	y, MD
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P	Physician /Medical Examiner		Immediata Causa (Finel diseasa or condition	Car	CINO	Me 1	sf.	the Co	1sr -	-		Onset and	Death
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	the death certificate be executed by the attending physician and ached for use as the burial-transit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Entar Undarfying Causa (Disaesa or Injury	b	ue to (or es a c	onsequance o	of):	ı		• •			
68760,	siciar Siciar 5 buri		triet initiated avants	c	ue to (or es a co		Λ.				-		
89	rtificat ng phy as th	Medical	rasulting in death) Last		de to (or es a co	or isequerice of	1).						
Вох	eath cer attendir I for use	Physician/		d							1		
	e dea the at hed fo	/sic	Part ii. Other significant conditions	ontributing to death but	not rasuiting in	tha undariying	g causa giv	an in Part i.	23b. Did to	bacco use co	ntribute to	the cause	of death?
P.0	res thet the de signed by the a i be detached f								1 🗆 Y	es 2 No	3 Prob	ably 4	Unknown
ds,	sign d be	d by							24a. Was a	n autoney	24h Wa	ra autops	v findings
of Vital Records,	e law requires hes been sign ge 2 should be	Completed							perforr		con	illable prion of leath?	rto
a	Tage de la la la la la la la la la la la la la								1 □ Ya	as 2 No	10	Yes 2	Ø No
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of	5 00	7	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 LI Inpatiani			DUA	4 LI Nursing Ho	ma 5 ⊠ Rasida 28d. Dascribe ho			)	
Ou	ding h. After funer	to 1	1 ■ Natural 5 □ Pending	28e. Data of injury (Month, Dey	Year) in	jury	28c. injun Worl	k? Yas 2□No	200. Dascribe in	W injury occur.	ed		
Division	To the Hospital or Attending Phwitin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Certification:	2 Accident invastigatio 3 Suicida 6 Could not b datarmined	00- 01	y - At homa, fan (Specify)			THE PERIOD	28f. Location (St City or Town		er or Rural	Routa Nu	ımber,
	To the Hospital within 24 hours a To the Funeral Completely filled	edicai C	29a, Certifiar (Check only one)	yeiclan: To tha best of niner: On the basis of a and mannar stete	xamination and	daath occurre or investigetion	ed et the timon, in my of	na, data and piece, pinion, daath occur	end due to the co	euse(s) end ma ate end place,	annar as sta and dua to	ated. tha cause	n(s)
	To the within 2 To the comple	Me	29b. Signatura and titla of certifier			2	9c. License	e number	2	9d. Detę signe	d (Month, I	Day, Year)	
	->-0		NR JAM	and			019	576		6/21/	197		
		f	30. Name end addrass of person who	complated causa of dee	th (Item 23e) (1	SPC4/	chenn	Ru.	Berlin	Mn	21	+11	
	Sta	te	31. Data filed (Month, Day, Year)	32. Registrer		P	13.1		- 4 [[1]	• 1	CI	- '/	
	Registr.	ar	.IIIN 2.4	1997 Melini	Muchan	Workelle							

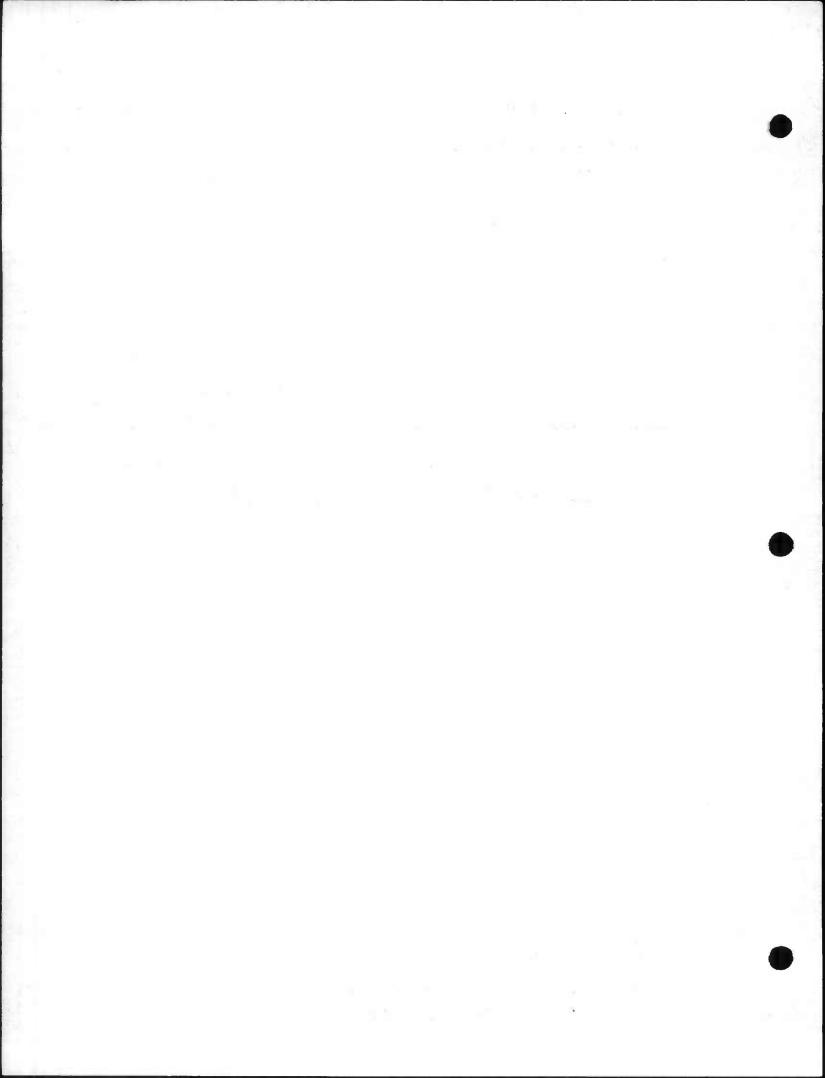


State of Maryland / Department of Health and Mental Hygiene

Cartificate of Death

21280

						Cei	rtificate o	f Death		Reg. No.		_ 1 _ 0 0
п	Physic	ian	Decedant's Name (First, Middla, La	st)					2. Data of I	Daath Day	Yaar	3. Time of Death
	/Medi		GEORGE JAK	PMAN					6	- 26 -	97	10:599.1
	Exami		4a. Facility Neme (If not institution, giv		er)			4b. City, Town,	or Location of De	The state of the s	of Death	
			ATLANTIC GENER	AL HOSP	TAI			BEKLI	N M.O.	WO	RCEST	TER
	Funeral		5. Social Sacurity Number 6. S	Sax / 7.	Aga (In yrs. las	st birthday)	If Undar 1 Ye	er If Under 24 I	Irs. 8. Data of I		9. Birthpl	aca (Stata or Foreign
	Director		217-14-8257	SYM 2□ F	83	Yrs.	Months Dey	s Hours N	Min. (Month, 5 - 2)	O- 14	Count	
1	P .	1	Usual Residence of Decedent								-	
	show	_	10a. Stata 10b. County			Town or Lo	cation				10	Od. Insida City Limits
	W J	9	NU Atlant:	ic County	Ple	easan	tville					1 AYas 2 No
	中 9 2 8 8	Director	10e. Straat and Number				10f. Zip Code	•		10g. Citizan of	Whet Count	iry?
	23a	<u>e</u>	1200 Lincoln Ave	enue			082	232		Ţ	J.S.	
	eep E	Funeral	11. Maritel Status	12. Was Dacede Armed Forca	nt Ever in U,S.	13.	Was Decedent of	f Hispanic Origin	(Spacify Yes or I uarto Ricen, etc.)	No- 14. Rec	ce - Amarice	en Indien,
0	72 hours efter death with the Maryland "natural", or freme 23a or 28a-f show sqical Examiner must be notified at		1 ☐ Navar Married 2 ☐ Married	1 ☐ Yes 2 ☐ If Yas, Give			1 ☐ Yas 2 ☐ N		surto ritoon, oto.,			
21215-0020	ours	1 by	3 Widowad 4 □ Divorced	Year or Datas	s:	0.5	المرابعة وها الما	o opecity.		Specif	A: DTC	ICK
5-	72 h natu	Completed	15. Dacedant's Ed (Specify only highest gra	ducetion ada complatad)		16a. Deced	lant's Usual Occ	cupation ne during most of ired)	workina	16b. Kind of B	usinass/ind	ustry
2	within ene. then	문	Elamentary/Secondary (0-12)	College (1-4d	or 5+)	lifa.						
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inc	2 E 5 X	Be	17. Fathar's Nama (First, Middla, Last)	,						lle, Maiden Sumar	na)	
Yes		2	Isaac Jarman					Lavin	ia Denni	S		
Maryland	2 8 8 8		19a. Informant's Name/Raiationship (	Type, Print)			-			nbar, City or Town		
	C = 00 F		Lucinda M. Evans						. O. Box	1252, P.	leasar	ntville,NJ
altimore,	ges 1 e it of He if Item or othe		20a. Mathod of Disposition 1   ■ Burial 2 □ Cremation 3 □	Removal from Sta	20b. Pla	ce of Dispo netery, crar	sition (Nama of natory or other p	/ace)	Dete	20c. Location	- City or Tov	wn, Stata
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at	permit. Pages Department of Important: If it eny injury or once.		21. Signature of Funeral Service Liven	1500		22	. Nama and Add		_			
Ω	89 = 8 8		1						n Funera	ry, MD 21	1801	
			23a. Pert1. Enter the disease, or com	lications that cous	ed the death.	Do not ent						Approximata Intarval Batween
V	Physician		shock, or haart failura. List only	ona causa on aach	ı iina.							Onset end Death
d	/Medical	Н	Immediata Causa (Final	CTAT	c Cun	CVE	DAM DO	e Duran	0-0 1110	A4116 0114	- W	IN
н	Examiner		diseasa or condition rasulting in daath)	a. SEPI	Due to /or e	C / /	Hance of TO	RECTO-VAR	CHAL EIST	COUS DWI		24 HRS.
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	certificate be executed ding physician and se as the buriel-transit	Examiner	Sequentially list conditions	b	Dua to (or e							3 DAYS
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99	rtifica ng ph as ti	Jed	lasuring in daarii) Last	LEAT	- DERIL	1110	INFILT	OITE			1	3 DAYS
XO	2 2 3	an/M		d	P F-14 /1	ILAIN	11/1/16/1	ME				0/1/8
Ö.	0 0 0	Physician	Part II. Other significant conditions of	ontributing to death	but not rasulti	ng in the u	ndarlying ceusa	givan in Part I.	23b. Di	d tobacco use co	ntribute to	the cause of death?
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		by F	DM 4									
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000	- 40	olet	ALZHEINER'S	DISEA	SE_				pe	rformed?	com	npletion of ceuse laath?
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ō	Phys ir this erai d		27. Manper of Death	28a. Data of In	njury 2	8b. Time of	28c. In			e how injury occur		/
Division	Attending In death.  Sctor: After by the funer	tio	1 ☑Natural 5 ☐ Pending 2 ☐ Accidant invastigation		Day Year)	Injury		/onk? □Yas 2□No				
<u>is</u>	f or Attendition after death.  Director: A in by the fu	fica	3 Suicida 6 Could not be		Injury - At hom	a, farm, str	aet, factory, offic	e	26f. Location	(Street and Numb	ber or Rural	Routa Number.
ă	aftar Direct	Certification:	4 Homicida	building,	etc. (Specify)		aet, factory, offic		City or 7	own, Stata)		
	spita nours nerai		29a. Certifiar 1 Certifying Phy	ysicien: To the bas	st of my knowle	odge, daath	occurred at tha	tima, data and pie	ace, and due to th	a causa(s) and ma	anner as sta	ated.
	- Ho 24 h	edicai	(Check only 2 Medical Exam	Inar: On the besis end mennar	of axamination	and/or inv	astigation, in my	opinion, daath o	ccurred at the time	a, data and place,	and dua to	the ceuse(s)
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Me	29b. Signature end titla of certifier				29c. Lice	nse number		29d. Data signa	d (Month, D	Pay, Yaar)
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			30. Nama and addrass of person who of	ompleted source -	I death /llam 0	2a) /Tu		050929		6-27	-47	
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			0011	331								



State of Maryland / Department of Health and Mental Hygiene 97 2 | 28 |

			Cer	rtificate of	Death		Reg. No.	1 41	201
Physici	an	Decedent's Name (First, Middle, Last)	LEROY	v	Y 4 37	2. Dete of De Month	ath Day	Yeer	. Time of Deeth
/Medic	al	ORVILLE	LEKU		JAY		24, 1997		10:45 p
Examin	ıer	4a. Fecility Neme (If not institution, give street and number)			4b. City, Town, or L		, , , , , , , , , , , , , , , , , , , ,		
		Memorial Hospital  5. Social Security Number 6. Sex 7. Age (In	yrs. lest birthday)	If Under 1 Year	Cumber1			egany	
Funeral Director		177-16-5225 XXM 2□ F 79 Usual Residence of Decedent	, ,,,	Months Deys	Hours Min.	8. Dete of Bird (Month, De 2-16-		Country)	(Stete or Foreig
naturel, or Hems 23a or 28a-f show		10a. Stete 10b. County 10c	c. City, Town or Lo	cation				10d. I	Inside City Limits
Fed a	ţċ	PA. BEDFORD	CLEARVII	LLE				1	1□Yes XXN
23a or 28 Int be not	al Director	10e. Street and Number RD#2 BOX 28R		10f. Zip Code	15535		10g. Citizen of V		
jane. Ithan "naturel", or Items 23a or 28a-f show Tra Medical Experient rount by notified at	by Funeral	11. Marital Status  1 Never Married  3 Widowed 4 Divorced  12. Was Decedent Ever Armed Forces?  12. Was Decedent Ever Armed Forces?  12. Was Decedent Ever Armed Forces?  12. Was Decedent Ever Armed Forces?  12. Was Decedent Ever Armed Forces?  12. Was Decedent Ever Armed Forces?  12. Was Decedent Ever Armed Forces?	i i	Was Decedent of H I Yes, specify Cuba I □ Yes 2000No	lispanIc Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	14. Rac Bled	e - American Ir ck, White, etc.	
S H	b	15. Decedent's Education	16e. Deced	lent's Usuel Occup	pation	1	16b. Kind of Bu		
E 05	Completed	(Specify only highest grede completed)	(Give I	kind of work done OO NOT use retire	during most of world)	king			,
	E O	Elementary/Secondary (0-12) College (1-4or 5+)	LIFET	IME FARM	ER		FARMIN	NG	
od o	To Be C	17. Fether's Neme (First, Middle, Lest) ALVA JAY		-	18. Mother's Nam	e (First, Middle, E M. MO		10)	
E 12		19a. Informent's Name/Relationship (Type, Print) DEBBIE CLARK	19b. Mallin		end Number or Ru RVILLE, PA		er, City or Town,	Stete, Zip Coo	(e)
Department of Healt important: If item 2: any injury or other		20e. Method of Disposition 20 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	ob. Place of Dispos cemetery, crem FAIRVI	sition (Neme of netory or other pla EW CEMET)	ce) ERY	Date 6-27	20c. Locetion -		
Departr imports eny inju		21. Signature of Funeral Service Licensee		. Name end Addre	ess of Fecility	L SVC.	22 W. M EVERET	MAIN ST	
nysician Medical xaminer		23e. Part1. Enter the disease, or complication that caused the cau		tive Pulm			1651,	Inte Ons	proximete prval Between set end Death
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is certificate director, pag	Be (	25. Was case referred to medical examiner?			26. Place of Deat	th (Check only o	ne)	-	
0 0	2	Hospitel:	2 ER/Outpetient	t 3 DOA Oth	er: 4 🗆 Nursing Ho	ome 5 Resid	lence 6 Oth	er (Specify)	
The Tree	Certification:	27. Manner of Death  1 Naturel 5 Pending 2 Accident Investigation  28a. Dete of Injury (Month, Day Yea	28b. Time of Injury	28c. Injur Wor M 1 🗆	y et rk? Yes 2 □ No	28d. Describe h	ow injury occur	red	
ed in by	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp	At home, farm, stre ecify)	eet, factory, office		28f. Location (S City or Tow	Street end Numb m, State)	er or Rural Rou	ute Number,
within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) 11A Certifying Physician: To the best of my 2 Medical Exeminer: On the basis of examend menner stated.	knowledge, death ninetion end/or inv	occurred et the tin estigetion, in my o	me, dete end place, pinlon, deeth occur	end due to the d red et the time, d	cause(s) end me date end plece,	enner es steted end due to the	ceuse(s)
To t	Σ	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signe	d (Month, Dey,	Year)
15		18/Comer.		D 1	4865		JUNE	25 19	97
hil		30. Neme end eddress of person who completed cause of deeth (		•					
		Dr. Robustiano Barrera-Memor	cial Medi	ical Buil	ding-Cuml	berland,	MD 21	502	
Stat	te	31. Dete filed (Month, Day, Year) 32. Registrar's Si	ignature						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 1997 **Physician** 30, Corwin Tirrell Jewell, Jr. June 3:20 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4469 World Farm Road Oxford Talbot 5. Social Security Number 7. Age (In yrs. last birthday) If Undar 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 12, 1925 9. Birthpleca (State or Foreign Country) New York 6. Sex **Funeral X** M 2□ F Months Days Hours 71 Yrs. Director 105-18-7960 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location ahow. 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f ahor other traumatic event, the Medical Expriner must be notified at 1 ☐ Yas 2 ☑ No Oxford Maryland Talbot 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21654 USA 4469 World Farm Funeral Road 12. Was Decedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, White, etc. 1 NYes 2 No If Yes, Give 1 ☐ Nevar Married 2 ☑ Married 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Datas: White WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mantel Hygien Important: If fern 27 is marked other the any injury or other treasment. Chemical Engineer Publishing 12 18. Mothar's Nama (First, Middla, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Corwin T. Jewell, Sr. Frances Kested 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Seth Shannahan Jewell/Wife 4469 World Farm Rd., Oxford, Maryland 21654 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Chesapeake Cremation 1 ☐ Burial 2 【Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 7/7 Chester, Md 21619 Center LLC. re of Funeral Seprice Lig 22. Nama and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 200 S. Harrison St. Easton, MD

23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart tellure. List only one cause on each line. 21601 Approximate Interval Between Onset end Death Physician to Bruin and Spine /Medical Immediate Ceuse (Final Phreinoma 4 mg disease or condition resulting in death) Examiner ettending physicien end for usa es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical that initiated evants rasulting in death) Last Due to (or as a consequence of) signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □Ves 2 □ No 3 □ Probably 4 □ Unknown þ 24b. Were autopsy tindings available prior to complation of causa of death? Be Completed 24a. Wes an autopsy performed? revous page 2 1 ☐ Yes 2 DHNo 1 ☐ Yas 2 ☐ No certificate 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only she) 1 Yes 2 7 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 8 Other (Specify) Certification: To this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t 28b. Time ot 28d. Describe how Injury occurred 1 Natural 5 Pending investigation I Director: A 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours eff To the Funeral Di completely filled in Medical 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, deta end place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifiar 29c. License numbar 29d. Data signad (Month, Day, Year) D08715 30. Name end address of person who completed cause of deeth (ftep 23a) (Type, Print) William H. Wood, 506 Idlewild Ave., Easton, MD 21601 Jr., MD

Registrar

**DHMH 16 Ray 6/95** 

State

31. Dete tiled (Month, Day, Year)

JUL - 2 1997

32. Registrar's Signeture

with the Maryland

hours after

altimore, Maryland 21215-0020

certificate be axecuted

Box 68760.

P.O.

Records,

Division of Vital

Hospital or Attending Physician:

death.

efter



				State of Marylar		ent of Health a cate of Death	and Mental Hy	01	21283
	Physici /Medic		1. Decedent's Name (First, Middle, Last) ALEXANDE	2	10/	NSON	2. Date of Do	eeth Dey 199	3. Time of Deeth 7:15AM
	Examir Funeral Director		213-36-2704	VDEL H. 7. Age (In yrs. 58	OS DITA lest firthday) If U Yrs. Mon	L Glei		ch ANNE	eath /
	yland		Usual Residence of Decedent  10a. Stete 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
	88-f sh	Director	MARYLAND ANNE ARUNI	DEL ANN	APOLIS				1 X Yes 2 □ No
	with the		10e. Street end Number		10f	Zip Code		10g. Citizen of Whet	Country?
020	d 2 should be filed within 72 hours efter death with the Maryland the nd Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified.	by Funeral	12 MONUMENT STREE  11. Marital Stetus  1 □ Never Married 2 □ Married  3 □ Widowed 4 ※ Divorced	ET  2. Wes Decedent Ever in U Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:	If Yes,	21401 ecedent of Hispenic Origonal Specify Cuban, Mexican Specify:	gin? (Specify Yes or No , Puerto Rican, etc.)	US  14. Rece - A Bleck, W  Specify: BI	
21215-0020	d within 72 ho jiene. r than "natur the Medical	Completed	15. Decedent's Educa (Specify only highest grede Elementary/Secondery (0-12)	ation completed) College (1-4or 5+)	16a. Decedent's (Give kind o life. DO NO	f work done during most T use retired)	t of working	16b. Kind of Busine	ss/Industry
	al Hyg	BeC	17. Fether's Neme (First, Middle, Last)		LADOR	18. Mothe	er's Name (First, Middle	, Meiden Sumeme)	EMPLOTED
Maryland	d Menid to marked	2	ALEXANDER JOH		10h Mailine Add		RENCE SNOWI		7-0-4
	127 F		19a. Informent's Name/Reletionship (Type ADELA BROWN (SISTE			ress (Street end Number ERN AVE . Al			e, Zip Gode)
altimore,	permit. Pages 1 and Department of Healt Important: if Item 2: any Injury or other once.		20a. Method of Disposition    ↑ Burial 2 □ Cremetion 3 □ Real 4 □ Donation 5 □ Other (Specify)	moval from State ANN	Place of Disposition emetery, cremetory IAPOLIS ME	(Neme of or other place) EM. GARDENS	Dete 7/7/97	20c. Location - City ANNAPOLIS	
Bal	permii Depar Impor any ir		21. Signature of Funeral Service Licensee	Leone	WM. F	e end Address of Facility EESE & SONS EST ST. AND	S MORTUARY,		
	Physician		23a. Pert1. Enter the disease, or complication shock, or heart failure. List only one	ations that caused the deet ceuse on eech line.	h. Do not enter the	mode of dying, such as	cardiac or respiretory e	errest,	Approximate Intervel Between Onset and Death
	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death) e.	Cancel Due to (c	r es e consequence	ne esopolinal bla	hagus		months
-	pet usit	Examiner	b.	gastra	ointest	inal bla	reding		days
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x 68760,	death certificete be executed e ettending physician end xd for use es the buriel-transit	/Medical	thet initieted events resulting in deeth) Lest	Due to (o	r es e consequence	of):			
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ls, P.O	requires that the de neen signed by the e hould be deteched t	by Phy						Yee 2□No 3□	
ecord	been s	Completed			-			en eutopsy ormed?	b. Were eutopsy findings evelleble prior to completion of cause of deeth?
E E	ilcien: The law certificete hes rector, pege 2	e Cor	OF Man and referred to wealthy.				10		1 ☐ Yes 2 ☐ No
Vital		0	25. Was case referred to medical examiner?  1 Yes 2 No	spitel:	ER/Outpetient 3	Other	of Deeth (Check only rsing Home 5 ☐ Resi		necify)
sion of	Affei fune	ation: T	27. Manner of Death  1 Deaturel 5 Pending investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe	how injury occurred	
Division	5 # \$ E	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, ferm, street, fac	story, office	28f. Location ( City or To	Street end Number or wn, State)	Rurel Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physic 2 ☐ Medical Examine	clan: To the best of my known: On the besis of exemination and manner stated.	wledge, death occur tion end/or Investiga	red et the time, dete end tion, In my opinion, deat	d place, end due to the th occurred et the time,	ceuse(s) end menner dete and plece, end o	es steted. lue to the cause(s)
	To the Within To the	Me	29b. Signeture and titled certifier	7	1	29c. License number		29d. Date signed (Mo	onth, Dey, Yeer)
			I Chinele	fellich-	Jane	H482	141	July	1, 1997
			30. Name and eddress of person who com Cherelle Reddick	Fleted cause of deeth (Item K-Lane	North	H482 Arundel	Itaspital	Glen B	ital Drive
ľ	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrer's Signe	ture	2	,		

State of Maryland / Department of Health and Mental Hygiene

97 2128

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Yeer MABLE LOTTIE **JOHNS** June 28 1997 8:30 p /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Easton Talbot If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F 79 Yrs Director 220-03-8983 Mar.6,1918 Maryland Usuel Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Madical Exertities must be notified at MD Talbot. Easton Director 1 Yes 2000 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6371 Old Trappe Road 21601 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours efter o Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumstic event, the Medical Examples. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: þ 3X Widowed 4 ☐ Divorced Black Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Easton Elementary/Secondery (0-12) Coltege (1-4or 5+) Memorial Hospital Nurses Aide 6 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Samuel Brice Lottie Mable Walley 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Lottie Mable Barrow/Daugh! 6371 Old Trappe Rd., Easton, MD 21601 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1 ☐ Bunal 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Spring Hill Cemetery 7-2 Easton, Maryland 21. Signeture of Funeral Service Licanses 22. Name and Address of Fecility Eskow Framptom-Hawkins-Eskow Funeral Home PO Box 43, Federalsburg, MD 21632 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest shock, or heart feilure. List only one cause on each line. **Physician** Immediete Ceuse (Final diseese or condition resulting in death) /Medical Examiner Examiner Endstage ettending physician end for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events Box 68760. Physician/Medical Due to (or as e consequence of) resulting In deeth) Lest Division of Vital Records, P.O. Pert II. Other significant conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? Disorder, Non insulin Dep. DM 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy tindings evelleble prior to completion of cause of deeth? Completed 24a. Wes en autopsy Anemia of chronic disease 1 Tes 1 ☐ Yes 2 ☐ No this certificate To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certifics completely filled in by the funeral director, I Be 25. Wes case reterred to medical exeminer? 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 1 Yes 2 No Other: 4 Uursing Home 5 Residenca 6 Other (Specify) 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury et Work? 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end menner es steted.

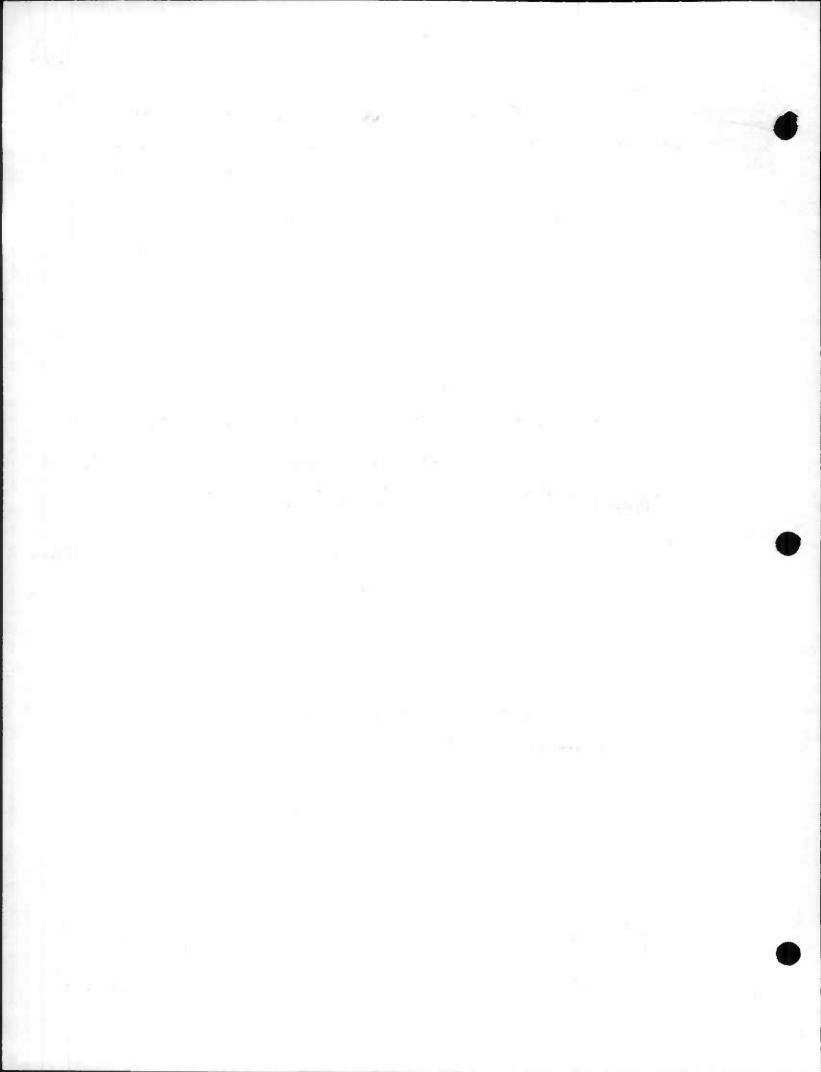
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner steted. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) MD 21629 Robinson Lappin, M.D., Shore Clinical Found., 920 Market St. Denton

DHMH 16 Rev 6/95

State Registrar 31. Date tiled (Month, Day, Year)

JUL - 2 1997

32. Registrer's Signeture



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.7

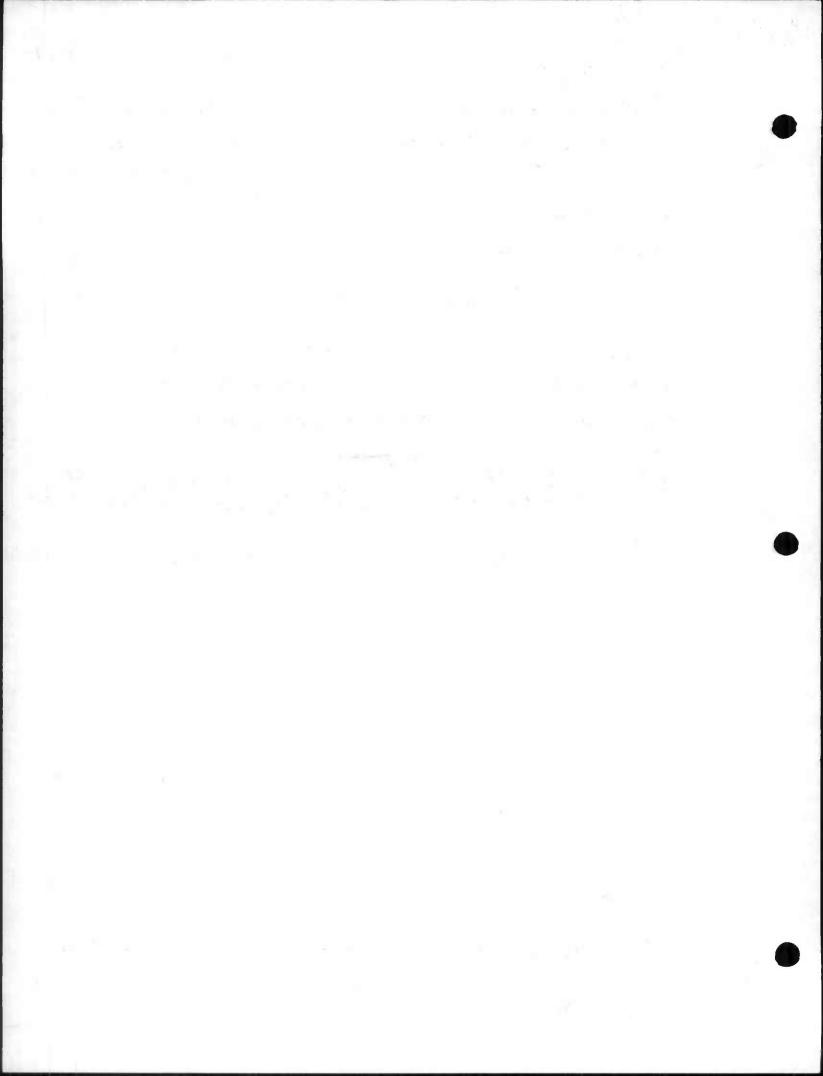
			Decedent's Nam	o (First Middle Las	41		Cer	tificate	of I	Death	O Data of D	Reg. No.		21200	
	Physici	an			NSAL						2. Date of D Month	Day	Year	3. Time of Death	
	/Medi	al	PREN							0't. T	JUNE			2:00 PM	
	Examir	er	4e. Fecility Name (/						4	lb. City, Town, or I	Location of Dea	tn 4c. Coun	ty of Death		
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	Funeral				9X	ge (in yrs. i	last birthday) Yrs.		Days	Hours Min.	8. Date of B	ay, Year)	9. Birth	place (State or Fore ntry)	ign
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	land		10a. State	10b. County		10c. City	, Town or Lo	ation						10d. Inside City Lim	its
	Mary -1 sh	٥	MARYLAND	ALLEGAN	Y	CUM	BERLAN	D						1 Yes 2 □ N	No
	1 the	Directo	10e. Street and Nur					10f. Zip C	Code			10g. Citizen o	What Cou	ntry?	
	30 o	0	1054 R	CHWOOD A	VE.			2	1502	2		Ind	ia		
	deatl	Funeral	11. Maritel Status		12. Wes Decedent	Ever in U,	S. 13. V	as Decede	nt of H	ispanic Origin? (S n, Mexican, Puert	pecify Yes or N		ce - Ameri		
20	filed within 72 hours after death with the Maryland Hyglena. ther than "natural", or items 23s or 28s-f show sht, the Medical Examiner must be notified at	by Fu	1 ☐ Never Marri 3 ☐ Widowed	ied 2 Married	Armed Forces' 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:	No		Yes, specif		n, Mexican, Puert Specify:	o Rican, etc.)		other	<sup>etc.</sup> r Asian o Islander	r
õ	tura tura	Pa		15. Decedent's Ed			16a Deced	ent's Usual	Occupi	ation		16b. Kind of			
15	d within 72 hor glena. ir than "nature in the Medical E	Completed		ify only highest gra	de completed)		(Give life. L	kind of work O NOT use	done d	ation during most of wor l)	rking	TOD. WING OF	Dusinessin	dustry	
212	y with	E O	Elementary/Seco	1 2	College (1-4or	5+)		SE KE				HOUSE	KEEPI	ER	
P	Hygled other	Be C	17. Father's Name					61		18. Mother's Nar	ne (First, Middle	, Maiden Suma	me)		
Maryland 21215-0020	12 should be filed v n end Mantel Hygle 1s marked other I reumatic event, In	To E	RAGHBIV	GARG						KRISHU	A (U	NKNOWN)			
an	sho s me		19a. Informant's Na	ame/Relationship (7	ype, Print)		19b. Mailin	g Address (	(Street	and Number or Ru	ıral Route Numi	ber, City or Tow	n, State, Zip	Code)	
Σ	alth alth		DR SUNIL	GUPTA	SON IN	LAW	1054 R	ICHWO	OD A	AVE CUMB	ERLAND 1	MARYLAN	0 2	1502	
Baltimore,	permit. Pages 1 end 2 should by Department of Health end Mante Important: If item 27 is merked eny Injury or other treumatic e 000.02.		20a. Method of Disp			0.0	lace of Dispos	sition (Name	e of ner plac	e)	Date	20c. Location	- City or To	own, State	
Ĕ	Pagenent: Murt: Mury o		4 Donation	Cremation 3 ☐ 5 ☐ Other (Specify	Removel from State  )	)					1, 199	7 CUMBE	RLAND	MARYLAND	ŀ
alt	mit. ports y Inju		21. Signature of Fu	neral Service Licen	X97 - 1		22	Name and	Addres	ss of Fecility	DAT HOM	-			
Ω	20 E 2 8			J. 41	Mount					AMS FUNE R STREET			DVIANI	D	
			23a. Part 1. Enter th	he disease, or comp rt failure. List only o	lications that cause	d the death							KILAN	Approximete	
الم	Physician		snock, or nea	rt fallure. List only t	one cause on each i	iine.								Intervel Between Onset end Death	
	/Medical		Immediate Cause (	Final	<sub>a</sub> Metasta	tic e	ndomet	rial (	card	rinoma			1	months	
	Examiner		resulting in deeth)		a. IICCUBCU		r as a conseq		care	LITOMA				Months	
	70 €	iner		_	h										
	The law requires that the death certificata be executed ta has been signed by the ettanding physician and paga 2 should be detached for use es the bunet-transit	Examiner	Sequentially list co	nditions,	D	Due to (or	r as a consequ	uence of):					Ť		
90,	cian d		Sequentially list confirmed any, leading to imcause. Enter Under Ceuse (Disease or	orlying inlury	C										
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o.	the de	ysic	Pert II. Other algnif	icent conditions	entributing to death t	out not resu	ılting in the ur	derlying cau	use give	en in Part I.	23b. Did	l tobacco use c	ontribute t	o the cause of deat	th?
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3e	has has by	mpi												death?	
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Zit N	ysicien: The la is certificata har director, pega 2	Be	25. Was case reference examiner?	,	Hospital:				Oth	26. Place of Dea					
	Phys this ral di	٦.	1 ☐ Yes 2.2 27. Manper of Deat	NO	143 Inpati		ER/Outpatient 28b. Time of			4 Li Nuising F		how injury occ		(y)	
NS.	Jing I	lon	1 Natural	5 Pending investigation	28a. Date of Inju (Month, Da	ay Year)	Injury	M 200	c. Injury Work	Yes 2 □ No	26d. Describe	now injury occi	nred		
KANSAI	Attending Physicien: or death. ector: After this certific by the funeral director,	Ical	2 ☐ Accident 3 ☐ Suicide	6 Could not be		iun. At ho	me farm etro			162 Z 🗆 NO	28f Location	(Street and Nun	ther or Run	al Route Number.	
	7 2 2 5	Certification:	4  Homicide	determined	building, e	tc. (Specify	)	et, lactory,	OHICO		City or To	wn, State)	iber or nare	a) Mode Walliber,	
PREM Di	ours erel		29a. Certifier	™CertifyIng Phy	sician: To the best	of my know	vledae deeth	occurred at	the tim	a date and place	and due to the	causo(s) and s	200001 200	tated	
Д	24 h	edical	(Check only one)	2 Medical Exam	Iner: On the basis of and manner st	of examinat	ion and/or inv	estigation, in	n my of	pinlon, death occu	rred et the time	, date end place	, and due t	o the cause(s)	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Me	29b. Signature and	tive of certifier				29c.	License	e number		29d. Date sign	ed (Month,	Day, Year)	
	->-0			Ja . Lou	5-			D '	3328	80		1	20	1997	
	1		30. Name and addre	ess/of person who	ompleted cause of	death (Item	23a) (Type I		) کا در	0		June	30,	(//,	
	MU			PTA M.D.,					01,	CUMBERLA	AND, MD	21502			
	Sta	te	31. Date filed (Moni			rar's Şignat				-					
	Registr	ar	7,11	11 02 199	della d	modus	-Randall.								

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					Ce	rtificate	of Death	,	Reg. No.		
			1. Decedent's Neme (First, Middle, Last,	1	11-	SELI	NIC	2. Data of Da Month	_	Year	3. Time of Death
	Physici /Medic		IDA	M.	KE-	5661	0.	June	26	1997	8:30pm
	Examir		4e. Fecility Neme (If not institution, give				4b. City, Town, or	Location of Deet	4c. County	of Deeth	
			Charlestown Re	etirement C	Commun	ity	Catonsv	ille	Balt	imore (	City
	Funeral		Social Sacurity Number     6. Sax		s. last birthday	Months I	Yaar If Under 24 Hrs Deys Hours Min.		th V Year)		e (State or Foreign
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	Pu ≥		Usuel Residence of Decadent  10a. Stete 10b. County	100 (	City, Town or Le	costino					
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	Ne M	etc.		re city c	aconsvi						1√ Yes 2 No
	Vith t	Funeral Director	10e. Streat and Number 209 S 709 Maide	n Choice Tan	0	10f. Zip C	21228		10g. Citizen of V		7
	s 23	erai				W. 5 4			U.S.A		1-4
	ar de item	L L		12. Was Decedent Evar in Armed Forces?	0,8. 13.	If Yas, specify	nt of Hispenic Orlgin? (S y Cuban, Mexican, Puer	opecity Yas or No to Rican, etc.)	- 14. Hac	a - American k, White, etc	
20	rs aft	by F	1 ☐ Nevar Married 2 ☐ Merrled  3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yas 2X No If Yes, Give Yaar or Dates:		1 □ Yes 2	No Specify:		Specify	Whit	te
5-0020	s 1 and 2 should be filed within 72 hours after death with the Meryland if Haelth and Mental Hyglena. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ite Medical Exampler must be notified at	Pa	15. Decedent's Edu		16e Dece	dent's U <i>s</i> uel (	Occupation		16b. Kind of Bu	reinnee/Indue	in
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an	id be ental ked c	To Be	Harry Wicks				Elizak	oeth My	ers		
Maryland	shound M mar	-	19e. Informent's Name/Relationship (Ty	pe, Print)	19b. Maili	ing Address (S	Street and Number or R			State, Zip Co	ode)
	end 2 selth e n 27 is		Mrs. Jeanne K. Li	ntner			Drive, Woo				
ē,	of Haelth Item 27		20e. Method of Disposition	20b.	Pleca of Dispe	ositlon (Name	of	Dete	20c. Location -		, State
JO L	Peges nent of h ant: If ite		1 NBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donetion 5 ☐ Other (Specify)	emovel from Stata	cemetery, cra codlawn			5/30/97	Baltimo	re M	
Baltimore,	그는 원주		21. Signature of Funeral Sarvice Liganse				Addrass of Facility	7,30737	Darchic	ic, in	,
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	Physician /Medical		Immadiata Cause (Final	0 A- 0	4 0	1	0 0	~			
8	Examiner		diseese or condition resulting in death)				mula De	slost.	_		Ylon.
		ē		Due to	(or es e consa	quance of):					
	petr Insit	Examiner		).						i	
Ć,	anecu n enc	Exa	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseesa or Injury	Due to	(or es a consa	quance ot):				I	
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of Vital	ysician: is certific director,	To Be	axaminer?	lospital:	☐ ER/Outpetie	nt 3 DOA	0.1	eth <i>(Check only</i> dome 5 ☐ Resi		or (Speciful	
0	Phy or this erel o		27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Tima o		: Injury at Work?		how injury occur		
on	tending Ph leeth. or: After th the funerel	itio	1. Naturel 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	м	Work? 1 ☐ Yes 2 ☐ No				
Division	Atter r dee ector by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At	home, farm, st	reet, factory, o	office		Street and Numb	er or Rural R	loute Number,
ă	al or afte	ert	4 LI Homicide	building, etc. (Spec	eity)			City or To	wn, Stete)		
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by			Iclen: To the best of my kr							
	n 24 n 24 ne Fu	edical	(Check only 2 Medical Examinations)	end manner steted.	etion end/or In	ivastigetion, in	n my opinion, deeth occu	urred et the time,	date end pleca,	end due to th	e cause(s)
	To the Hospital or Attending Physician: white 24 hours after deeth.  To the Funeral Director: After this certifical completely filled in by the funeral director.	ž	29b. Signetura and title of certifier	- 11		29c. l	Licensa number		29d. Date signe		
			Benn	> m/n	-		0264	73	June	27,	1997
			30. Neme end eddress of person who co	mpletad cause of deeth (Ite	em 23e) (Type,	Print)					
_			DERNARD F	Kozcovsky		711 6	AIDEN	CHOIC	E LA	NEZ	1220
	Sta	te	31. Deta filed (Month, Day, Year)	32. Registrans Sign	ature	24					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Theodore Morris Kimble Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 2:30AM heodore Kimble June 30 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Hospital Baltimore of Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) **Funeral** Months Days 1MM 2□ F Yrs. 63 Director 212 34 6381 Dec. 22, 1933 West Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ahow The Medical Examiner must be notified at MD Allecany Westernport 1 ☐ Yes 2 N No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21562 22612 Westernport Road, S.W, U.S.A. deeth Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ™ Yes 2 □ No If Yes, Give Year or Dates: Korean Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) Hygiena. College (1-4or 5+) Elementery/Secondary (0-12) permit. Pages 1 and 2 should be filled w
Department of Haalth and Mental Hygien,
Important: If Nem 27 is marked other tha
any injury or other traumatic except the Power Boiler Operator Pulp & Paper 12th. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Charles Adam Kimble Mary Thelma Mackley 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Steven Kimble 106 Morning View Drive, Keyser, WV 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State Potomac Hemoial Gardens 7/3/97 Keyser, West Virginia 4 Denation 5 Other (Specify) 21. Signature of Fineral Service Line 22. Name and Address of Facility 2/224 Approximete Intervel Between Onset end Deeth Physician /Medical Immediate Ceuse (Finel Rupture of thoracic aprilic aneurysm 45 minutes disease or condition resulting in death) Examiner Examiner physician end Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequence of): as ad by the e Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? signad by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension 24b. Were eutopsy findings eveilable prior to completion of ceuse of death? Completed 24a. Wes en eutopsy performed? peed this cartificata hes 1 🗆 Yes 1 ☐ Yes 2 No Division of Vital 25. Was cese referred to medical examiner? Be 26. Plece of Deeth (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Inpatient 2 ER/Outpetient 3 DOA 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Naturel death. 1 ☐ Yes 2 ☐ No 2 Accident or Attend efter death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital o within 24 hours of To the Funeral DI completely filled in Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner es steted.

Medicat Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) end manner stated. 29a. Certifier edicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) A52402321-TH-9527 Isell, MD, PhD 10 ynn Hartsell, MD, PhD Sinai Hospital of Baltimore Baltimore, MD ZIZI5 37. Registrar's Signeture Registrar



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State of Maryland / Department of Health and Mental Hygiene	1	')	1	1	×	2
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1			Ginger Cove He	ealth Car	re Center				An	napo	lis	Ann	ne Aru	ndel	
Ī	Funeral Director			6. Sex 1 □ M 2013 F	7. Age (In yrs. la.		If Under Months	1 Yea Days	If Under	-	8. Date of Birth (Month, De) July 27			elece (State	te or Foreign
	p.		Usual Residence of Decedent												
	a-f show	Funeral Director	MD Anne A	rundel	10c. City,	Ann	cation apoli	s					1		City Limits es 2 X No
	7 28	i e	10e. Street end Number				10f. Zip	Code				10g. Citizen of	What Cour	itry?	
	h wii	a D	4000 River Cr	escent D	rive			2	1401			Unite	d Sta	tes	
	deat	ner	11. Marital Status	12. Wes Dec	edent Ever in U.S.	. 13.	Was Dece	dent of	Hispenic Or	gln? (Spe	ecify Yes or No- Rican, etc.)		ce - Americ	an Indien	,
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Bal	Deper Impor any In		21. Signature of Funaral Service L	censee	2/	22	2. Name er	ike	ess of Fecili	John ouce	M. Tay	lor Fur	eral	Home	, Inc.
	Physician		23a. Part1. Enter the diseese, or of shock, or heart failure. List of	complications that inly one ceuse on	caused the deeth. each line.									Approxim Intervel E Onset en	nate Between
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth)	e	on g Ex he	c l	18an	*	forte	ext				6	reas
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s, P.O	requiras thet the deeth c een signed by the ettenc hould be datached for us	by Ph	<sub>     </sub>								1 🗆 1	/es 2□No	3 🗆 Proi	pably 4	Unknown
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	ician: The lav certificete hes rector, paga 2	Eo									1 D Y	es 2XXVo	15	∃Yes 2	2□ No
tal	tifice tor, p	0	25. Was case referred to medical						26. Place	of Deeth	(Check only o				
>	Physician: this certific ral director,	0	exeminer? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2 E	R/Outpatier	nt 3□ D0	DA O	her:		me 5 ☐ Resid		her (Snecil	v)	
on of	Attending Phy ir deeth. ector: After this by the funeral of	tion: T	27. Manne of Deeth  1. Naturel 5 Pending 2 Accident investiga	28e. Dete (Mor		8b. Time of Injury		28c. Inja		1	28d. Describe h			,,	
Division of Vital	To the Hospital or Attending Ph within 24 hours eftar deeth. To the Funeral Director: After thi completaly filled in by the funeral	Certification:	3 Suicide 6 Could not determine	ned 286. Plac	e of Injury - At hom ling, etc. (Specify)	ne, farm, str	eet, factor	y, office	1		28f. Location (S City or Tow	Street end Num n, Stete)	ber or Rure	I Route N	lumber,
	To the Hospital or within 24 hours effa To the Funeral Dirticompletaly filled in	edical C	29a. Certifier  (Check only one)  1 Certifying 2 Medical E	xaminer: On the b	e best of my knowl besis of examinetic oner steted.	edge, death on end/or in	occurred vestigation	et the t	ime, dete en oplnion, dea	d plece, e	end due to the ded et the time, d	ceuse(s) end m	enner es s , end due to	teted.	e(s)
	o the o the omple	M	29b. Signature end title of certifier	City iiidi	statos.		290	c. Licer	se number			29d. Date sign	ed (Month.	Day, Year	r)
	F 3 F ŏ		John B	(1/1/1	done 1	10		D30					02,		
			20 Name and did	jui.	m ~					_				2771	
			30. Name end eddress of person w							100	,	-573-11		1 61 1	0.1
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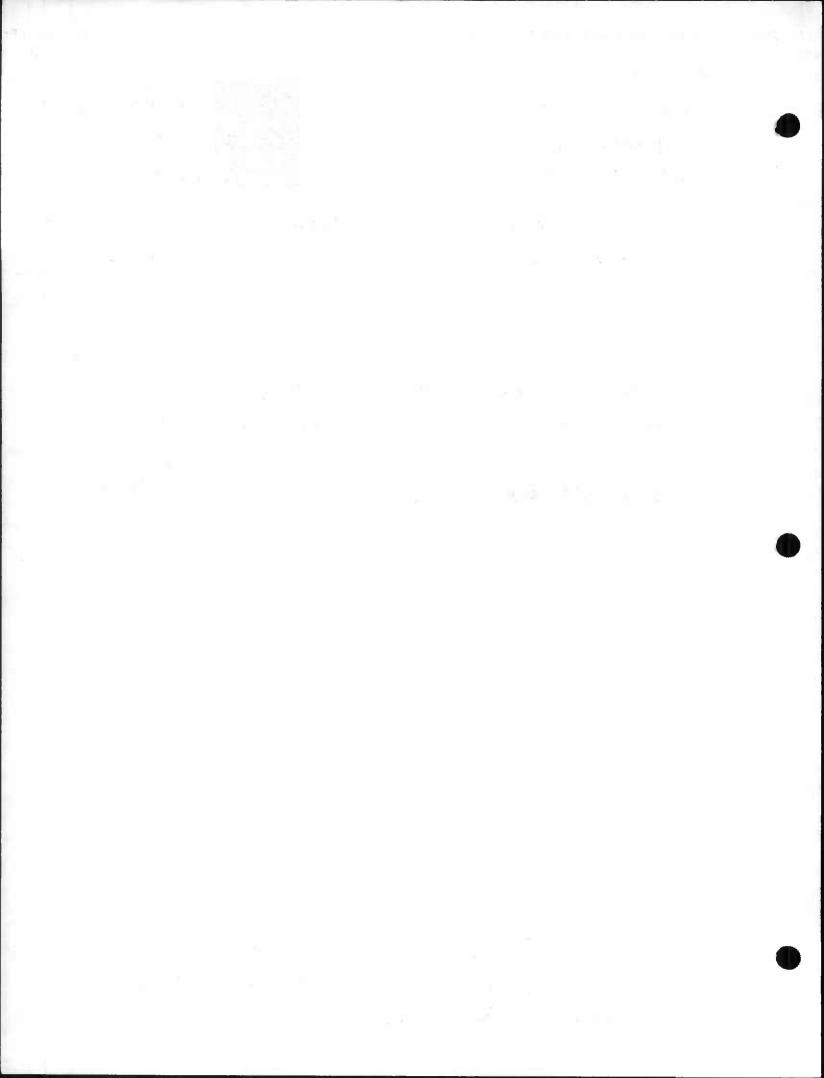
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8	/Medi Examir		4e. Fecility Neme (If not institution, give	street end number)					own, or Loca	ation of Deeth	4c. County	of Deeth		
			Salisbury Center:	Genesis E	lderC	are		Salis	sbury,	, MD	Reg. No.  If Deeth 22 1997 6:45 PM  Deeth 4c. County of Deeth Wicomico  If Birth (Deeth Wicomico)  If Birth (Deeth Wicomico)  If Birth (Deeth Wicomico)  If Birth (Deeth Wicomico)  If Birth (Deeth Wicomico)  If Birth (Deeth Wicomico)  If Birth (Deeth Wicomico)  If Birth (Deeth Wicomico)  If Birth (Deeth Wicomico)  If Birth (Deeth Wicomico)  If Birth (Deeth Wicomico)  If Birth (Deeth Wicomico)  If Birth (Deeth Wicomico)  If Birth (Deeth (Deeth Wicomico)  If Birth (Deeth (Deeth (Deeth County))  If Deeth 4c. County (Stete or Foreign (Deeth (Deeth County))  If Yes 2 No   If No. 10d. Inside City Limits 1 Yes 2 No   If No. 11d. Rece - American Indien, Bleck, White, etc. Specify: White			
	Funeral Director		5. Sociel Security Number 6. So 214-28-8581	ex 7. Age	(In yrs. lest	birthdey) Yrs.	If Under 1 Y Months D	eer If Unde bys Hours	Min.	B. Dete of Birth (Month, Dey July 6,	Year)	Cour	ntry)	ign
	Marylend Fed at	tor	10a. Stete 10b. County	comico	10c. City, T	own or Lo		lisbur	У			1		
	or 28	Director	10e. Street end Number				10f. Zip Co	ie		1	0g. Citizen of V	Vhet Cour	ntry?	
	23a	Ta	1525 Wood	ridge Dr.				21804			U.	S.A.		
21215-0020	d within 72 hours after death with the Maryland plane. r than "natural", or items 23s or 28s-f show the Wedgel Experies must be rectified	by Funeral	11. Meritel Status 1 ☐ Never Married 2 ☒ Merried 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:			Wes Decedent If Yes, specify 1☐ Yes 2反			ify Yes or No- ican, etc.)	Blec	k, White,	etc.	
5-0	72 ho	Completed	15. Decadent's Ed (Specify only highest grad		1	6e. Deced	dent's Usuel O	cupetion	et of working	,	16b. Kind of Bu	siness/In	dustry	
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	permit. Pages 1 and 2 should be filed Department of Health and Mentel thy Important: If item 27 is merked other any injury or other traumatic event, once.		20e. Method of Disposition	WIIC	20b. Pleci	e of Dispo	sition (Neme o	f	DI.					_
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		$\vdash$	23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of	olicetions that caused the	ne deeth. [	Do not ent						y , 11	Approximate	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	e. M.e.							U.S.A.  Tes or No- Specify: White  16b. Kind of Business/Industry  County Government  Middle, Meiden Sumeme)  Bertha Smith  Ten Number, City or Town, Stete, Zip Code)  Lisbury, MD 21804  10c. Location - City or Town, Stete  Salisbury, MD  705 E. Main St.  Salisbury, MD 21804  Privatory errest,  Approximate Intervel Between Onset end Deeth  CANCEL SMICK  Approximate Intervel Between Onset end Deeth  Main St.  Salisbury, MD 21804  Approximate Intervel Between Onset end Deeth  Main St.  Approximate Intervel Between Onset end Deeth  Main St.  Approximate Intervel Between Onset end Deeth  Approximate Intervel Between Onset end Deeth  Main St.  Approximate Intervel Between Onset end Deeth  Approximate Interve		2	
		<u>_</u>	rooding in dodding	Di	ue to (or es	e conseq	quenca of):		0					
,0,	ata be executed hysician and the buriel-transit	icai Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b	ue to (or es	e conseq	quence of):							
Box 68760,	t tha death cartificata b by tha attending physic teched for usa as the b	Physician/Medica	that initiated events resulting in deeth) Lest	d	ue to (or es	e conseq	uence of):							
	death a atte	icia	Part II. Other significent conditions co	ntributing to death but	not resultin	a in the u	nderlying caus	a given in Pert	1.	23b. Did to	bacco uee cor	ntribute to	o the cause of deat	h?
s, P.O	es that the igned by th be dateche	by Phys								-				
Record	aw requir ss bean s 2 should	Completed										av	eilable prior to	S
		Col								1 □ Y	es 2 2 No	1[	☐ Yes 2 KNo	
Vita	ician: The l cartificata he ractor, page	Be	25. Was case referred to medical exeminer?	Hospital:					e of Death (	(Check only or	10)			
of	Physician: this cartific	10	1 ☐ Yes 2 ☑ No 27. Manner of Deeth	1 ☐ Inpatient		Outpatien					enca 6 Other		(y)	
O	Aftar fune	tion	1 Naturel 5 Pending 2 Accident investigation	(Month, Day \	Year)	Injury		Injury et Work? 1 ☐ Yes 2 ☐		od. Describe II	ow injury occurr	90		
Division of Vital	Hospital or Attanding 24 hours efter daath. Funeral Diractor: Aftar Italy filled in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)							Bf. Location (S City or Town		er or Run	el Route Number,	
_	To the Mospital or Attand within 24 hours efter deatl To the Funeral Diractor: complataly filled in by tha	edical C	29a. Certifier (Check only one)  Certifying Phy 2 Medical Exam	/stclan: To the best of r iner: On the basis of e and manner state	xamination	dge, death end/or inv	occurred et the	e time, dete e ny opinion, de	nd plece, en eth occurred	nd due to the c d et the time, d	ause(s) end me ate end pleca, o	enner es s end due t	teted. the cause(s)	
	To the within 2 To the compla	M	29b. Signature end title of cartifier					ense number	_	2	9d. Dete signed		4	
			1 - hote	5 ans				39.	813		61	241	(47	
	30		30. Name end eddress of person who o	completed ceuse of dee		le) (Type,	Print) 1104	Health	way Dr	., Sal	isbury,	MD	21804	

10 State

Registrar

31. Date filed (Month, Dey, Year)
JUN 24-1997

32. Registrer's Signature



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9.7

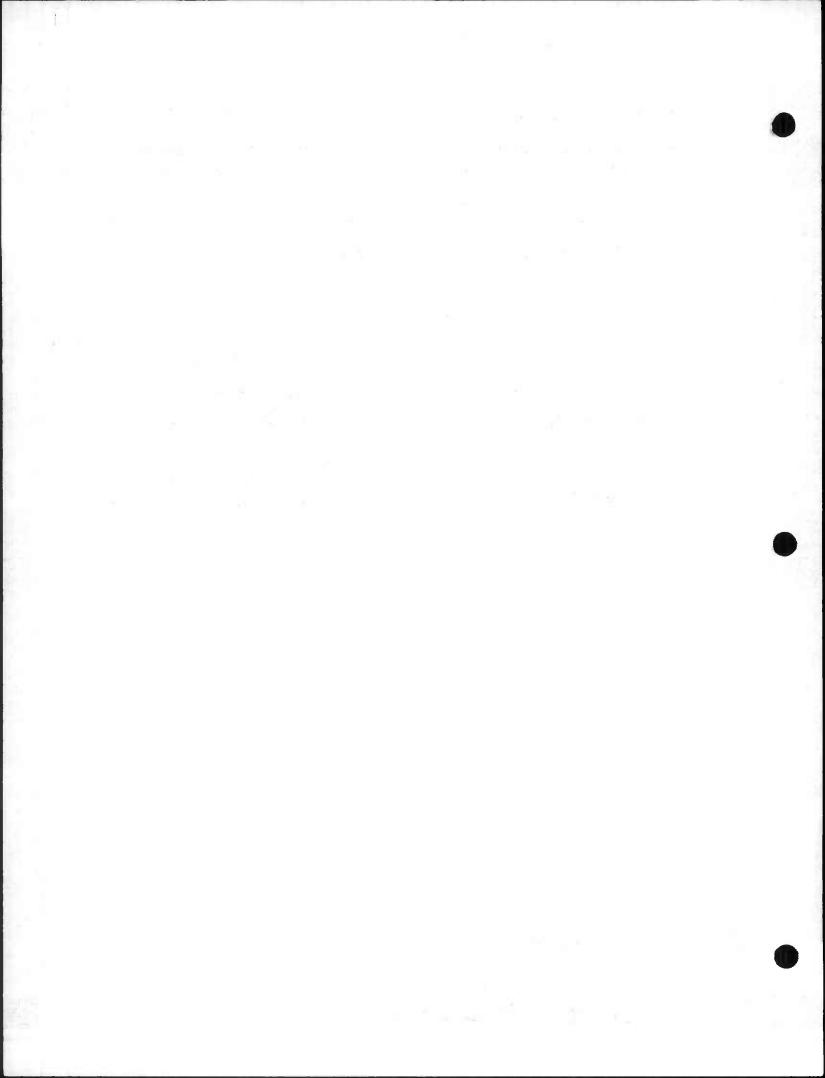
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		Item # 5,				Certific	ate of D	eath	2. Dete of De	Reg. No.		3. Time of Death		
Phys /Me	ician dical	Leon H	. LL	oyd					June Month	13 19	97	2041		
Exam		4e. Fecility Neme (If not							Location of Deet					
_		Peninsula  5. Sociel Security Numb			cal			Salish If Under 24 Hrs		Wico		10		
Funer Directo		206-20-02 Usuel Residence of Dec	226	MM OFF	8	Yrs. Month		Hours Mir	. (Month, Da	3 1929	Penn	ace (State or Foreign ry) 1 <b>sylvani</b> a		
ter deeth with the Marylend frems 23a or 28s-f show frem mast be notified at	_	10a. State 10t	o. County			Town or Location			-		10	od. Inside City Limits		
the M	Director	PA 10e. Street end Number			Ph	iladel	Dhia Zip Code			10- 00	10%			
with with		7270 Nam	efield	Arronno		101.	19138	2		10g. Citizen of		луг		
deeth ms 2;	Funerai	7270 Man	sileid	12. Was Decedent Ev	er in U,S.	13. Was De			Specify Yes or No		e - America	an Indien,		
The state of the s								rto Rican, etc.)	Bla Specif	ck, White, e	etc.			
2 hou	e d	15.	Decedent's Edu	ucation	1	16e. Decedent's U	suel Occupat	ion	V-000	16b. Kind of B				
within sne.	Completed	Elementary/Seconder	nly highest gred y (0-12)	College (1-4or 5+)		(Give kind of life. DO NO Police		ring most of wo	orking					
nd 2	BeC	17. Fether's Neme (First	, Middle, Last)					8. Mother's Na	ame (First, Middle	, Maiden Surner	ne)			
vre, Maryland s 1 end 2 should be file if Heelth end Mentel Hyg Itam 27 is merked othe other traumatic svent,	5	Herman	S. LL	oyd				Gilber	ta E.	Gibbo	ons			
Maryland d 2 should be file th end Mentel Hy 7 is marked othe traumatic svent	Ι.		Reletionship (T)	vpe, Print)		_						Code)		
1 end 1 Heelth am 27 I				(Wife)				Ld Ave						
S 55 7 9		19a. Informent's Name/Reletionship (Type, Print)  19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)  7270 Mansfield Ave. Phila. Pa 19138  20a. Method of Disposition  1 Burial 2 Cremetion 3 Removal from State  20b. Plece of Disposition (Neme of cemetery, cremetory or other place)  20c. Location - City or Town, State												
Balting permit. Pe Depertmen Important: any injury	ouce.	21. Signature of Funera	Service Licens		KOLI	22. Name	end Address	of Fecility		WCDOC	10000			
m abes	8	17. Fether's Neme (First, Middle, Last)  Herman S. LLoyd  19a. Informent's Name/Reletionship (Type, Print)  Juanita LLoyd (Wife)  20a. Method of Disposition  1 Burial 2 Cremetion 3 Removal from State  18. Mother's Name (First, Middle, Maiden Sumeme)  Gilberta E. Gibbons  19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)  7270 Mansfield Ave. Phila. Pa 19138												
68760, tificate be executed expression and expression and expression expression and expression expression and e	edical Examiner	Cause (Diseese or injur- thet initieted events resulting in deeth) Lest	ons, liate	b	ue to (or es	s e consequenca o	of):							
Box seth cert stendin for use	N/			d							-			
deeth of deeth of for	sicia	Part II. Other eignificant	conditione co	ntributing to death but	not resultir	ng in the underlyin	g cause giver	in Part I.	23b. Dld	tobacco uee co	ntribute to	the cause of death?		
IS, P.O. BOX es that the deeth cer igned by the ettendin be deteched for use	by Physician/M						101		1 🗆	Yes 2□ No	3 Prob	ably 4 Unknows		
ecord ew requir ss been s 2 should	Completed									en eutopsy ormed?	com	re eutopsy findings llable prior to apletion of cause eeth?		
The in the interval in the i	S								1 🗆	Yes 2 No	10	Yes 2□ No		
ysician: Thy ysician: Thy s certificate director, peg	Be	25. Was case referred to exeminer?		Annaita I.					eath (Check only	one)				
- S 00	<u>2</u>	Yes 2 No	'	lospitel: 1 ☐ inpatient 28e. Dete of Injury		Outpetient 3 D	DOA Other 28c. Injury 6 Work?	4 Li Nuising	Home 5 Resi					
DIVISION  I or Attending lefter death. Director: After din by the fune	Certification:	1 X Naturel 5 [ 2 ☐ Accident	es 2 No	28d. Describe how injury occurred										
- 5 # 5 =	Certifi	4 Homicide	Could not be determined	28e. Placa of Injury building, etc.		e, farm, street, fac	ory, offica		28f. Location ( City or To	Street end Numt wn, Stete)	oer or Rurel	Route Number,		
To the Hospital within 24 hours To the Funeral completely filled	edical	29a. Certifier 1 (Check only one)	Certifying Phys Medical Exami	sicien: To the best of r ner: On the basis of ex end menner state	kamination	dge, deeth occurr end/or Investigati	ed et the time on, in my opi	, date end plec nion, deeth occ	e, end due to the urred et the time,	ceuse(s) end mo date end placa,	enner es ste end due to	ited. the ceuse(s)		
To the Within 2 To the	×	29b. Signeture end title	of cartifier			1	29c. License	number		29d. Date signe	d (Month, D	ley, Year)		
		20 Mars 121	mS	Buek		D.M.E.	D03599	)		06-13-9	97			
		JOHN T. BU					2010	13T TOWN	D37 140 0	1003				
S	tate	31. Date filed (Month, Da	N 2 4 19	00 8-1-1-1	Signature	Rarlell	CAD, S	PALTORU	KI, MD Z	TOOT				

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						Certificate o		F	eg. No.	61621						
	Physic	an	1. Decedent's Name (First, Middle, I	.ast)				2. Dete of Dee Month	Dey Y	3. Time of Death						
	/Medi		WESLEY DOYLE MC					JUNE	26 1	997 7:39 am						
	Exami	ner	4a. Facility Nema (If not institution, g				4b. City, Town, or L	ocation of Deeth	4c. County of	Deeth						
-	Funeral		FORT WASHINGTON  5. Social Security Number 6		ga (In yrs. last bi	rthday) If Under 1 Ya		INGTON 8. Data of Birth	PRINCE	GEORGE'S  Birthplace (State or Foreign Country)						
н	Director	n	259-50-0642	18 M 2□F 6		Yrs. Months Day	rs Hours Min.	8. Data of Birth Month, Day AD 1	3 <sup>year</sup> 1997	Country) GA						
	pu k		Usuei Residence of Decedant  10e. Stete 10b. County		10c. City, Tow	m or Location				40d facido Otto I imito						
	Aenyla F sho	٥	MD Prince	George's		ashington				10d. Insida City Limits 1 Yes 27 No						
	the N	rect	10e. Street end Number	deorge	10. 116	10f. Zip Code	<u> </u>	1	0g. Citizen of Wh	41						
	3a or	Funeral Director	12539 Monterey	Circle		: 20744			USA	,						
	ems a	Iner	11. Marital Stetus	12. Wes Decedent Armed Forces?	Ever in U,S.	13. Was Decedent of	f Hispenic Origin? (Spuban, Mexican, Puerto	pecify Yas or No-		American Indien, White, atc.						
20	be filed within 72 hours efter death with the Meryland tal Hyglene. d other than "natural", or flems 23a or 28a-f show event, the Medical Evarriner must be notified at	by Fu	1 ☐ Navar Marriad 2☐ Merried 3 ☐ Widowed 4 ☐ Divorced	1 Vas 2	No	1□ Yas 🍖 N		Thous, oto.,		Black						
Maryland 21215-0020	2 hours		15. Decedent's	Yaar or Datas:		. Decedent's Usuel Occ	cupetion		16b. Kind of Busi							
215	thin 7:	Completed	(Specify only highast g Elementary/Secondery (0-12)	rade completed) College (1-4or 5		(Give kind of work don life. DO NOT use reti VIANA	ne during most of work ired) O'ement:	king		Transportation						
21	ed withing ygiene.	Con	15	_5 <del>+</del>		rector, Info	rmation Se	ervice r								
and	S a S	Be	17. Fether's Name (First, Middla, La				18. Mother's Nam		Interest Contractor							
Z	d 2 should be filed v th end Mental Hygie 7 Is marked other t traumatic event, th	1º	John Matthew Mc 19e, Informant'a Name/Reletionship		19	. Meiling Address (Stre	Arnie Lo			tata Zin Coda)						
	D = -		Mildred McGuthr	У	1	<b>5</b> 39 Monter	ey Circle,	Ft . Wa	shington	, MD 20744						
ore,	of Health Item 27		20a. Method of Disposition		20b. Place o	f Disposition (Name of ry, crematory or other p enham VA Ce	viace)	100	20c. Location - Ci	ty or Town, Stele						
Ĕ	Peg ment: H ant: H ury o		1 Surial 2 ☐ Cramation 3 Donation 5 ☐ Other (Spec		Chelte	enham VA Ce	metery 7	7-2-97	Chelte <b>g</b>	ham, MD						
Baltimore,	permit. Peges 1 en Department of Heal Important: If item 2 any injury or other once.		21. Signeture of Funerel Service Lic	ensee		22. Neme end Add	dress of Fecility FT	LION FU	NERAL SE	RVICES						
	205 e d	4	SNGetter			P.O. Box	1351, Fore	estville	, MD 2074	47						
			23a. Pert1. Enter the disease, or co shock, or heert feilure. List on	mplications that caused y one cause on each li	d tha death. Do ne.	not antar tha moda of d	lylng, such as cardiac	or respiretory en	est,	Approximata Intervei Between Onset end Deeth						
	Physician / /Medical		Immedieta Causa (Final	shock, or heart failure. List only one cause on each line.  Interv. Onset  medieta Causa (Final eese or condition  Costo Corduo Canalf												
	Examiner		disease or condition resulting in death)	0.		consequence of):	TU BEST			FEW HOURS						
	p ti	liner		. b												
	tificate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions, if eny, leading to immediate		Due to (or es e	consequance of):										
68760,	sician buria	edical E	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlyling Cause (Disease or injury that initiated evants	C	Due to for one	consequence of):										
	ntificating physics as the	Medi	resulting in death) Last		Due to (01 es e 1	consequence or).										
Вох	ath ce ttendi	lan/		d												
	that the death cered by the attendin	Physician/M	Part fl. Other significant conditions	_			givan in Part I.	23b. Dld to	obacco use contr	ibute to the cause of death?						
, P.O.	The law requires that the death cer ite has been signed by the attendin page 2 should be detached for use	by Ph	(l'den)	carcinos endisc	ma of	the pr	rostati gla	nd 10 Y	es 2 10 3	Probably 4 Unknown						
rds	v requires been sign should by		Lunfa	100	Chilon !	Do .	V	24a. Wes a		24b. Were autopsy findings available prior to						
eco	e law requ has been ge 2 shoul	Completed		s que	Curcino		_	perior	lined!	completion of cause of deeth?						
<u>=</u>		Con						1 🗆 Y	es 2 DNo	1 ☐ Yes 2 ☑ No						
Vita	Physician: The this certificate and director, pag	Be	25. Was case referred to medical examinar?	Hospitel:		12	26. Piece of Dee	th (Check only or	ne)							
o	d is	: To	1 Yes 2 No 27. Menner of Deeth	1 Inpatie		Itpatient 3LI DOA			enca 6 Other							
on	ding th. : After e fune	27. Menner of Deeth 28a. Data of Injury 28b. Tima of finjury 4 Injury at Work? 4 Injury at Work? 5 Pending (Month, Day Year) 4 Injury at Work? 6 Injury at Work? 7 Injury at Work? 7 Injury at Work? 8 Injury at Work? 9 Injury at Work?														
Division of Vital Records,	er deer rector by th	Certification:	3 Suicide 6 Could not 4 Homicide determine	be d 28e. Plece of Inj building, etc	ury - At home, fe	erm, street, factory, offic	a	28f. Location (S City or Tow	treet and Number	or Rural Route Number,						
۵	ttal or ral Dir lled in			Danishing, Cit	o. (Opeany)											
	Hosp 24 hox Fune stely fi	edical		aminer: On the basis of	f examinetion en	e, deeth occurred et the d/or investigetion, in my										
	To the Hospital or Attending Ph within 24 hours effer deeth. To the Funeral Director: After th completely filled in by the funeral	Mec	29b. Signetura end title of cartifier	end menner ste	ovou.	29c. Lice	nse number	2	9d. Date signed (	(Month, Day, Year)						
	->-0		> Stu	enos		D	- 24687		6-8	17-97						
			30. Name end eddress of person wh	completed cause of d	leeth (Item 23e)	(Type, Print)	- 24687 6357 CX ONON HI	ON HILL	RD-	,						
			SANTIAG			R., M.D.	ONO N HI	LU, MD	, 2070	45						
	Sta Registr		31. Data filad (Month, Day, Year)  JUL 0 1 1997	92. Registr	er's Signatura	della										



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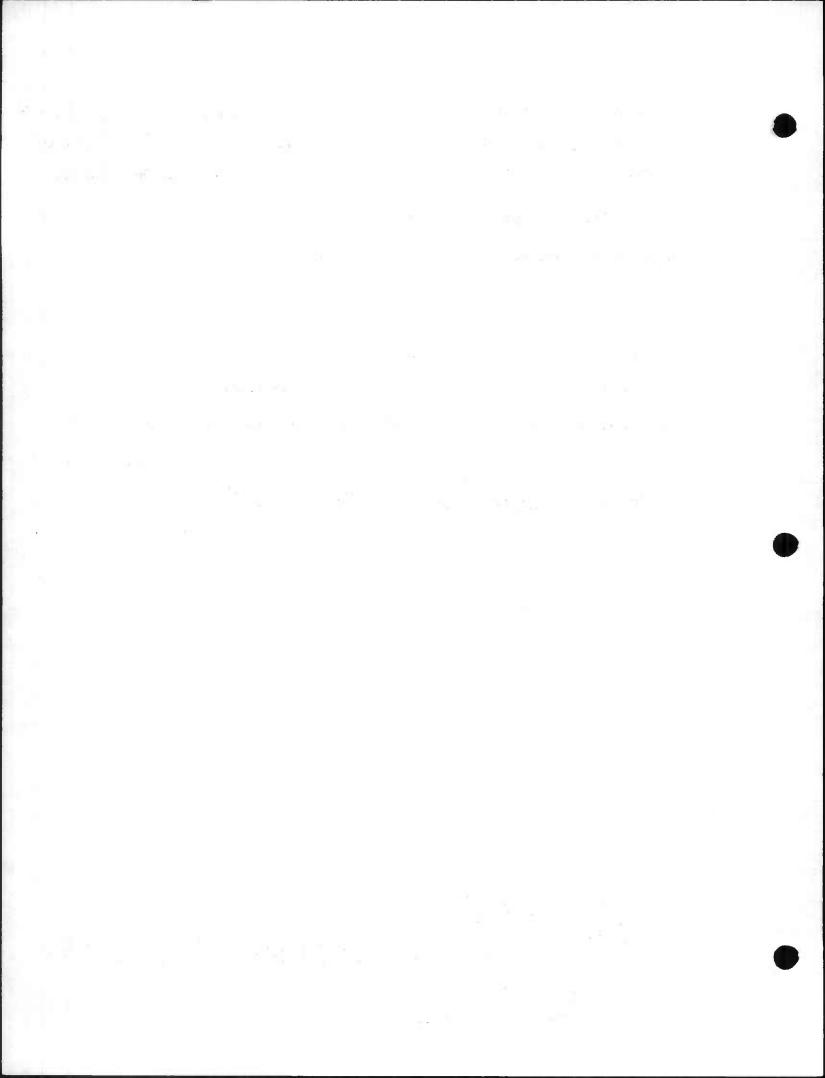
								rtificate of	Death		Reg. No.	, 64				
	Physic	ian	Decedent's Name (First,	Middla, La	st)					2. Date of Dee Month	oth Dey	Yeer	3. Time of Death			
	/Medi			ry	Emma		McKnight			June	28	1997	2:05PM			
	Exami	ner	4e. Fecility Neme (If not inst	itution, giv	a street and nur	m <i>ber)</i>			4b. City, Town, or L	ocation of Death	4c. County	of Death				
			Chesapeal	-					Arno1d			e Aru				
	Funeral Director		5. Social Security Number 229-74-4732		Sex I□M 2XIF	7. Aga (In ) 80	rs. last birthday) Yrs.	If Undar 1 Yaar Months Days	Hours Min.	8. Data of Birtl (Month, De) Sept 22	r, Year)		ece (Stata or Foreign ny) inia			
	pue *		Usuel Residence of Decede 10a. State 10b. Co			10c.	City, Town or Lo	ocation				10	d. Inside City Limits			
	Aaryl Sho	0			undel			vern				1	1 ☐ Yes 2√√No			
	the the same	9	10e. Street end Number					10f. Zip Code			10g. Citizen of	Minat Count				
	with we or	0	7409 Merri	nusic	Avenue	- Cir	ccle		21144		Anne A					
	eath m 23	era	11. Marital Status		12. Wes Dece					necify Yes or No-		ce - America				
21215-0020	ignes 1 and 2 should be filed within 72 hours efter death with the Maryland nt of Health and Mentel Hygiene.  If item 27 is marked other than "naturel", or items 23a or 28a-f show or other treumstic event, the Medical Examiner must be notified at	by Funeral Director	1 Never Married 2 ☐ 3 🖾 Widowed 4 ☐ Dive		Armed Fo 1  Yes If Yes, Giv Yeer or D	rces? 2 No		If Yes, specify Cub 1 ☐ Yes 2 🛣 No	Hispenic Origin? (Spen, Maxican, Puerto Specify:	Rican, etc.)	Bla Specif	ck, White, e	tc.			
0	2 should be filed within 72 hours end Mentel Hygiene. is marked other than "naturel", eurmetic event, the Mudical Exa	Completed	15. Dec	edent's Ed	ducation		16e. Dece	dent's Usuel Occup	petion		16b. Kind of B					
218	hin 7	ple	(Specify only I		ede completed) College (1	-4or 5+)	(Give	kind of work done DO NOT use retire	during most of word	king						
2	giene giene	, E	7	,		40/ 01/		Cook			F	ood				
Maryland	other vent	Be	17. Fether's Name (First, Mi	ddia, Last)	)				18. Mothar's Nam	na (First, Middla,	Maiden Surnan	na)				
la a	should b and Ment marked umatic e	To	Edd Reavis						Zella	Higgins						
a	2 sho end is me		19a. Informent's Name/Rele	tionship (	Type, Print)		19b. Maili	ng Address (Street	and Number or Ru	ral Route Numbe	r, City or Town	State, Zip	Code)			
	end alth		Betty Evans	(Da	ughter)		7409	9 Merrimu	sic Aven	ie Sever	n, Marv	land	21144			
ore	of He		20a. Method of Disposition		10	20	b. Place of Dispo	osition (Name of matory or other pla	ce)	Dete	20c. Location - City or Town, State					
Betty Evans (Daughter)  7409 Merrimusic Avenue Severn, Monta Vista Cemetery July 2, 1997 Ga  20c. Lo  20d. Method of Disposition  12 Purila 2 Cramation 3 Removel from State  4 Donetion 5 Other (Specify)  Monta Vista Cemetery July 2, 1997 Ga  22. Nama and Address of Facility on M. Taylor								Galax	. Vir	oinia						
alt	permit. Pe Depertmen Important: any injury ance.		19a. Informent's Name/Reletionship (Type, Print)  Betty Evans (Daughter)  20a. Method of Disposition 1∑Neurial 2 □ Cramation 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify)  21. Shoulture of Finantia Service Licensee  22b. Place of Disposition (Name of cemafory, crematory or other place)  Monta Vista Cemetery July 2, 1997 Galax, Virgation M. Taylor Funeral Filed Company (Specify)  22c. Nama and Address of Facility on M. Taylor Funeral Filed Company (Specify)  23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast.													
0	225.8		20a. Method of Disposition  1 Dete 20c. Location - City or Town, State  20b. Place of Disposition (Name of cemafery, crematory or other place)  4 Donetion 5 Other (Specify)  Monta Vista Cemetery July 2, 1997 Galax, Virginia													
Physician /Medical Examiner  Immediate Ceuse (Finel disease or condition resulting in death)  Physician /Medical Immediate Ceuse (Finel disease or condition resulting in death)  Pue to (or es e consequenca of):							Onset end Deeth									
	ificete be executed g physician end es the bunel-trensit	Examiner	Sequentially list conditions,	ſ	b	Due to	o (or es e consec	quence of):				i				
60,	be e)	a E	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated evants	1	C											
68760,	phys the	edical	rasulting in death) Lest			Due to	o (or as e conseq	uence of):				į				
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Вох	eth cert ettendin for use	clar										1				
o.	that the de ed by the deteched	Physiclan/M	Pert II. Other significent cor	ditions	ontributing to de	ath but not	resulting In the u	nderlying cause gi	ven in Pert I.	23b. Did to			the cause of death?			
٥.	igned by be detec	by Pt	pleural	ma	ss,	050	as n	1955,		101	No 2 No	3 Prob	ably 4 Unknow			
Records,	been s	Completed b		- 4	, ma	ligh	ant	pleura	l effuss	ion 24a. Wes a perfor	an eutopsy med?	con	re eutopsy findings ilable prior to apletion of cause eeth?			
æ	0 5 0	E O		hea	rttai	lure	Myp	ertens	ion	1□ Y	es 2 🗓 No		Yes 2□ No			
Viital	certificate rector, pag	Be C	25. Was case referred to me		Much	ive	pulmo	naryd		th (Check only or	**		100 2010			
>	Physician: this certific ral director,	To B	exeminar? 1 ☐ Yes 2 XXVo		Hospitel:	noatient 2	□ ER/Outpetier	nt 3 DOA Ott	05:	ome 5 Resid		er (Snecify	)			
of	유유		27. Menner of Deeth		28e. Dete	of Injury	28b. Time o			28d. Describe h						
0	Attending or death. ector: After by the fune	atio	1 Natural 5 □ Po 2 □ Accident in	ending restigation		h, Day Year	) Injury		Yes 2 No							
Division	al or Attending Ph s efter death. it Director: After th ed in by the funeral	Certification:	3 ☐ Suicide 6 ☐ C 4 ☐ Homicide	ould not be termined	286. Place	of Injury - Ang, etc. (Spe		eet, fectory, office		28f. Location (S City or Tow		ber or Rurel	Route Number,			
	To the Hospital or within 24 hours efter To the Funeral Director Completely filled in 1	edlcai (	29a. Certifier (Check only one) Cer	lifying Phi ical Exam	ysician: To the ninar: On the be end mann	sis of axam	knowledge, death ination end/or in	occurred et the tivastigetion, in my d	me, dete end place, opinion, death occur	, end due to the or rred et the time, o	eusa(s) end m date end place,	enner es sta end due to	ited. the cause(s)			
	To the within 2 To the comple	Me	29b. Signatura and title of ce	rtifiar		50		29c. Licans			29d. Dete signa	d (Month, D	Pay, Year)			
			In	n	2-6	20	uc		11955		6-	30-	77			
,			30. Name and address of person who completed cause of death (Item 23e) (Type, Print)  REBECCA D. ELON MD Broadneck Medical Center, April 210/									aald				
			REBECC		·	N M	D B	roadnec	12 Medi	cal Cen	ter.	MI	21012			
	Sta	ite	31. Date filed (Month, Day, 1	(ear)	32 R	egistrar's Si	gnature	00								

Alexander grade and a

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			Certificate			•	gierie Reg. No		<u></u>	. 1 5 2	•	
	Dharaini		Decedent's Neme (First, Middle, Last)			2. Date of Da Month			/oor	3. Time of De	eeth	
	Physici /Medio		Emmer Brice McMillan			Tine	28	3 0	ear	1:55	P.M	
	Examir		4a. Fecility Nema (If not Institution, give street end number)		b. City, Town, or L	ocation of Deat		c. County of				
			Southern Maryland Hospital		Clinton		_			ge's C		
	Funeral Director		5. Sociel Sacurity Number  215-24-5689  G. Sex  1 M 2 XF  7. Aga (In yrs. lest birthdey) Months  Yrs.  If Under 1	Deys	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Januar	$y$ , $Y_{ear}$	1906	Nort	ece (Stata or F in) h Caro	oreign lina	
	/land		10a. State 10b. County 10c. City, Town or Location						10	od. Inside City i	Limits	
	72 hours after death with the Maryland natural', or items 23a or 28s-f show pical Examiner must be notified at	tor	Maryland Prince George's Clinton							1 🗆 Yes 2	<b>X</b> No	
	or 28	Sirec	10e. Street and Number 10f. Zip C	Coda			10g. Ch	tizan of Wh	et Count	ry?		
	23a	al	11209 Keystone Avenue 2	2073	5			ted S Amer		25		
	terns	nue	11. Maritai Stetus  12. Was Dacedent Ever in U,S. Armad Forcas?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☑ No	ent of His fy Cubar	spanic Origin? (Sp n, Maxicen, Puerto	ecify Yas or No Rican, etc.)	-	14. Rece - Black,	Amarica White, 6			
20	s afte	by Funeral Director	If Yas, Giva 1 ☐ Yes 2	ĭ <b>X</b> No	Spacify:			Specify:	Bla	ck		
8	hour	pa pa	3 LA.Widowed 4 Li Divorced Yeer or Detas:  15. Decedent's Education 18a. Decedent's Usuel	Occupe	ation		16b K	Kind of Busi				
215	nin 72	Completed	(Specify only highest grada completed) (Give kind of work	dona di retired)	furing most of work	ing	100.1	and or bush	110337110	ustry		
21	filed within Hyglene. other than and, the Me	EO.	Elementary/Secondery (0-12) College (1-4or 5+) Homemaker					Own H	ome			
Maryland 21215-0020	tal Hygle d other event, to	Be	17. Fether's Neme (First, Middle, Last)		18. Mothar's Nam		Malder	Sumeme)				
<u>Y</u>	12 should be f h and Mantal h Is marked of raumatic eve	70	Jerry Brice		Mary B							
Mai	12 sh h and r Is rr traum		19e. Informent's Neme/Reletionship (Type, Print)  19b. Meiling Address (				-					
	1 and Haalt am 2 rther		David McMillan/ Son 11209 Keys  20e. Mathod of Disposition 20b. Plece of Disposition (Neme	e of		Dete		ocation - Ci				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mantal Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1  Burial 2 □ Cremetion 3 □ Ramoval from Stata 4 □ Donetion 5 □ Other (Specify)  Cematery, cremetory or oth Murray Cemeter	her plece	e) J	uly 1, 1997				th Car	olin	
Bal	Departimbor any in poce.		Signatura of Funerel Sarvice Licensae #M00690  22. Name end Address of Fecility Matthews Funeral Service, Inc. 308 Elizabeth Street, Wallace, North Carol									
			23a. Pert1. Entar the diseesa, or complications that ceused the death. Do not antar the mode shock, or heart feilure. List only one ceuse on each line.						-	Approximete Intarval Between		
	Physician								1	Onset end Dea	ath	
	/Medical Examiner		Immediate Causa (Final disease or condition resulting in death)	九州	- INF	Buci	Con	1		441	15	
		<u>-</u>	Que to (or es e donsequence of):			,			1			
	uted	Examiner	b. 07   T   1						i			
ó	exec en an rial-tra		Sequantially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury c.						1			
68760,	ficata be executed physicien and sthe bural-transit	edicai	Cause (Disease or Injury thet initieted events resulting in death) Last Dua to (or as a consequence of):						+			
	ng ph								i			
Вох	death certiff e attending od for usa es	Physician/M	d						1			
0.	0 0 2	/sic	Pauli. Other significant conditions contributing to death but not resulting in the undarlying cer	usa give	en in Pert I.	23b. Did	tobacco	use contr	ibute to	the cause of c	death?	
0	± ≥ %		LIEHADROTISMI SENER DOMEN	tia		10	Yes 2	2 No 3	☐ Prob	ebly 4□Un	known	
Records,	w requires that s been signed to should be deta	d by		9		24a. Wes	en outo	neu l	24h We	re autopsy find	linas	
Ö	77 00	Completed	LENAL NEWFICIENCY				rmed?	psy	ava	ilable prior to		
Re	@ 2 44	d L	Sacra Dea no - lating		11/	10		1./		leeth?		
25. Wes case referred to medical examiner?  Hospital: — Other								ETTING	1 .	Yes 2 No	)	
of Vital	Physician: this cartific ral director,	0	examiner?  1 Yes 2 No  Hospital: 1 Nopatient 2 ER/Outpatient 3 DOA	Othe				8 DOther	(Specify	)		
	ding Phys h. After this funeral d	T:U	27. Manner of Deeth 1 Netural 5 Pending (Month, Day Year) 28b. Time of Injury	c. Injury Work	et ?	28d. Describe	how inju	iry occurred	3			
Sio	Attending ir daath. ector: Aftai by tha fune	catic	2 Accident Investigation M		Yes 2□No							
Division	or Att	Certification:	3 ☐ Suicide 4 ☐ Homlcide  6 ☐ Could not be determined  28e. Piece of Injury - At home, ferm, street, factory, building, etc. (Specify)	office		28f. Location ( City or To			or Rure	Route Number	۲,	
	pital ours a sual Diffiled		29a, Certifier 1 1 Certifying Physician: To the best of my knowledge, deeth occurred at					A STATE OF THE STATE OF				
	To the Hospital or Attending Physician: The Is within 24 burs effect aleth.  To the Funeral Director: After this cartificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)  10 Certifying Physician: To the best of my knowledge, deeth occurred et control one)  11 Certifying Physician: To the best of my knowledge, deeth occurred et control one one of the basis of examination and/or investigation, in	n my op	olnion, deeth occur	and due to the red et the time,	deta en	d piace, an	d dua to	tha ceuse(s)		
	To th	Σ	29b. Signatura and the of certified 29c.	Licensa	number		29d. Da	ate signed (	Month, L	Day, Year)		
			Munder Press	1 2	4945	J	14	NE	24.	1997		
		Ì	30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)	1 2	ノー	-	, ~~1	the same of	-4	1-1-1		
			Michael D. Levine, M.D., 7801 Old Branch	h Av	renue #40	9, Clin	ton	, Mar	ylan	d 20735	5	
	Sta Registra		31. Dete filad (Month, Dey, Year)  32. Registrer's Signatura									

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 97 2 2 2 4

						Certificat	e of	Death		Reg. No.	f ha	, , , , , ,				
	Observatori		1. Decedent's Name (First, Middle, Las	it)					2. Dete of De Month		Yeer	3. Time #1	th			
	Physici /Medio		Richard C.	McIlwee					June		1997	1703				
	Examir		4a. Fecility Neme (If not institution, give					4b. City, Town, or								
			Sacred Heart					Cumberl		A1:	legan	У				
	Funeral Director		217-10-7077	ex 7. Age	(In yrs. lest bir	Yrs. If Under Months	Deys		(Month, De	th y, Year) 8,1918	9. Birthpl Count West	lece (Stete or try) Virgi	Foreign nia			
	and **		Usuel Residence of Decedent  10e. Stete 10b. County		10c. City, Town	n or Location					10	0d. Inside City	v Limits			
	e Maryl Ba-f sho	Director	WV Minera	1	Keys							1 X Yes				
	th with the 23s or 2		10e. Street end Number 396 Ward Avenue			10f. Zip	Code 2672	26		10g. Citizen of V	Vhet Count	ny?				
020	thin 72 hours efter deeth with the Maryland e. an "natural", or Itema 23a or 28a-f show Medical Examiner must be notified at	by Funeral	11. Marital Stetus  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 X Yes 2 □ No If Yes, Give Yeer or Detes:	0	13. Wes Dece If Yes, spe 1 \(\superscript{Yes}\)		Hispenic Origin? (Span, Mexicen, Puer Specify:	Specify Yes or No to Rican, etc.)	- 14. Race Biec Specify	e - America k, White, e	etc.				
9	2 hou		15. Decedent's Ed		WW II	Decedent's Usu	ei Occu	petion		16b. Kind of Bu						
215	c = 6	Completed	(Specify only highest gree	de com <i>pleted)</i>	+)	(Give kind of wo life. DO NOT u	rk done se retire	petion during most of wo ad)	rking	Tob. Turid of bu	Sillosariilo	ustry				
2	77 To be 100	Con	10		·/	Spinni	ng I	epartmen	t	Textile	e Man	ufactu	ring			
pur	be filed ntel Hyg d other event,	Be	17. Fether's Neme (First, Middle, Last)					18. Mother's Ne	me (First, Middle,	Meiden Sumem	Θ)					
yla		7	Unknown													
Mai	D-4 2 2				19b.											
e,	eal leaf		19a. Informent's Neme/Relationship (Type, Print)  Lena L. McIlwee  19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code 396 Ward Avenue Keyser, WV 26726													
Baltimore, Maryland 21215-0020	permit. Peges 1 Depertment of Inportent: If ite any injury or of															
Bal	Deper Impor any in		21. Signeture of Funerel Service Licens	Spinning Department  Textile Manufact  Spinning Department  Textile Manufact  18. Mother's Neme (First, Middle, Meiden Sumeme)  Unknown  Mary Katharine Hartman  Informent's Neme/Relationship (Type, Print)  Lena L. McIlwee  Method of Disposition  Method												
			23a. Pert1. Enter the disease, or comp shock, or heart fellure. List only of	licetions thet caused tone ceuse on each line	the deeth. Do r							Approximete	/een			
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	. acute		. 1	{\									
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	uted d ansit	Examiner	b													
Ó	rificete be executed ng physician end as the buriel-transit		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury	L	or es e c	consequence or):										
68760,	ysicia	edical	Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest	C	Due to (or es e c	onsequence of):					-					
	ng ph e as t	Med	resulting in deetil) Lest								į					
Box	th cer tendir or use	lan/		d							-					
-	the attenthed for u	Physician/M	Part II. Other significant conditions co	intributing to deeth but	t not resulting in	the underlying o	euse gi	ven in Pert I.	23b. Did	tobacco use con	tribute to	the cause of	death?			
s, P.O.	requires that the death cer ween signed by the attendir hould be deteched for use	by Ph							10	Yes 2□No	3 Prob	ebly 450	Inknown			
Records,	been s									en eutopsy med?	con	re eutopsy fin pileble prior to appletion of ca				
	The law ate hes b page 2 s	Completed			¥				10	Yes 2 No		leeth? ]Yes 2□ N	Vo Vo			
/ita	ysician: The	Be	25. Wes cese referred to medicel examiner?						eth (Check only o	ne)						
of	5 00	5	1 163 202 140	Hospitel: 1 Inpatien			JA		Home 5 Resid			)				
uc	After funer	ton:	27. Manner of Deeth  1 □ Naturel 5 □ Pending	28e. Date of Injury (Month, Dey		ime of 2 njury M	28c. Inju Wo	ryet ⊮rk? ]Yes 2 □ No	28d. Describe I	now injury occurr	ed					
Division of Vital	To the Hospital or Attanding Phywithin 24 hours efter death.  To the Funeral Director: After this completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined					7165 2 110	28f. Location (S City or Tox	Street end Numbern, Stete)	er or Rurei	Route Numb	er,			
_	4 hours	edical Ce	(Crieck only 2 Medical Exam	reicien: To the best of Iner: On the basis of e	my knowledge,	, deeth occurred	et the ti	me, dete end plece	e, end due to the	ceuse(s) end me	nner es st	eted.				
	thin 2 the f	Med	one)	end menner state	ed.											
	10	-	29b. Signeture end title of certifier  MC CUU	loud				4712		June 30						
	DI	İ	30. Name end eddress of person who c													
	1000		Nannette McCull 31. Dete filed (Month, Day, Year)	ough, M.D.		eton Dr	ive,	Suite C	Cumbe	rland, I	MD 2	1502				
	Sta	е	1111 0 9 1007	A Page	a Signature											

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DER ME

June 1

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** June 27, 1997 Anne F. MacDonald 11:15 PM /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner Gaithersburg Mediplex of Montgomery Village Montgomery 7. Age (In yrs. lest birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer) 5. Sociel Security Number Birthplece (State or Foreign Country) **Funeral** 1□ M 2□ F 189-10-3984 Yrs. Director 87 Apr. 14, 1910 PENNSYLVANIA Usuel Residence of Decedent death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "naturel", or flams 23a or 28a-f shot traumatic event, the Medical Examiner must be notified at Ne Yes 2□No Montgomery Director Gaithersburg 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20429 Ivybridge Court 20879 Funerai U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Peges 1 end 2 should be filed within 72 hours after o Department of Health end Mental Hygiene. Introortant: If them 27 is marked other than "neturel", or flem eny injury or other traumatic event, the Medical Event Mode. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No þ Specify: White 3√2 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker 12 Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Charles Reshenberg Fannir Irwin 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 20429 Ivybridge Court - Gaithersburg, MD 20879
of Disposition (Neme of Dete 20c. Location - City or Town, Stete Joan MacDonald Evans 20b. Piece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Sunset Memorial Park 6/30/97 Cumberland, MD 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility George-Upchurch Funeral Home, P.A. 202 Greene St., Cumberland, shock, or heart feilure. List only one ceuse on each line. 202 Greene St., Cumberland, MD 21502 Approximete Intervel Between Onset end Deeth Physician /Medical tmmediete Ceuse (Finel disease or condition resulting in death) SEPSIS YEAR Examiner Due to (or es e consequence of): Examiner DECUBITUS ULCERS 2 YEARS signed by the ettending physician end the detached for use es the bunel-trensit thet the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of) 2 YEARS MALNUTRITION Physician/Medical Due to (or es e consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed peed hes 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certific: director. 25. Wes case referred to medical examiner?
1 ☐ Yes 2 ▼No Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospi within 24 hou To the Funer completely fil 29a. Certifier 1 Certifying Physictan: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner es steted. Medical 2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) D30692 June 30, 1997 6 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Gabriel A. Berrebi, M.D., 15200 Shady Grove Road, #305 Rockville, MD

DHMH 16 Rev 6/95

State

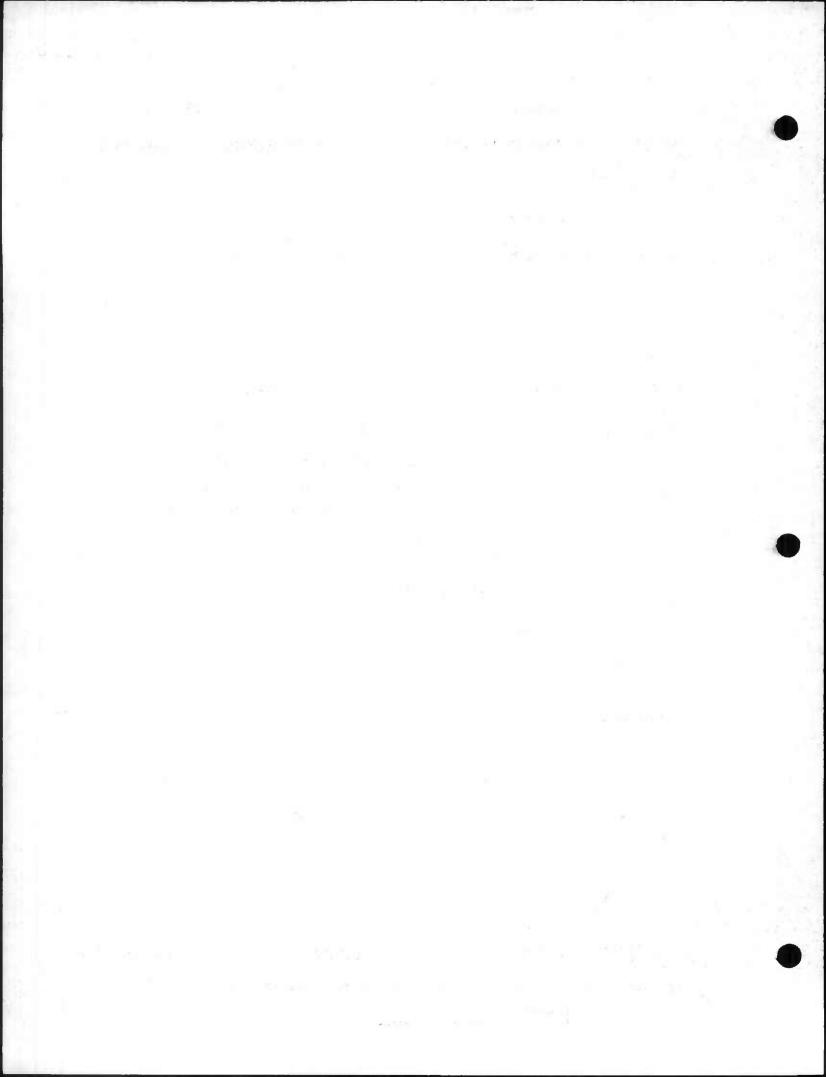
Registrar

31. Dete filed (Month, Day, Yeer)

JUL 03

32. Registrer's Signeture

Shi Stevelson Ren



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						Certifica	te of	Death			Reg. No.		
			1. Decedent's Neme (First, Middle, L	ast)						2. Dete of De	eth		3. Time of Death
	Physici		Betty AN	D)		McKe	9			JUNE	28,	1997	13:55 PM
	/Medi		4e. Fecility Neme (If not institution, ga	ive street and numbe	r)	1 162 - 11		4h City To		ation of Death		of Dooth	
È	Examir	ner	THE JOHNS HOPE		•			BALTI		CITY			_
Н						h down If I lode	er 1 Yea					IMOR	
	Funeral			Sex 7. A 1 □ M 2X F	Age (In yrs. last birt	Yrs. Months			Min.	8. Dete of Bir (Month, Da	th ly, Yeer)	9. Birthpl Coun	lece (State or Foreign try)
	Director		425-58-6521		66	113.			J	June 2	24,1931	. Ala	ıbama
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						1	Od. tnside City Limits
	sho	<b>&gt;</b>	MD TALBO	יתי	OXF							"	Maria City Laints
	Ne N	octo			J OMI (								
	£ 6	Director	10e. Street end Number			10f. Z	p Code				10g. Citizen of V	Whet Coun	try?
	ath with the Marylan 23a or 28a-f show		214 SOUTH MOR	RRIS STRI	EET		21	654			U.S	. A.	
	items items	Funeral	11. Marital Status	12. Wes Deceden Armed Forces	t Ever in U,S.	13. Was Deci	edent of	Hispenic Ori	igin? (Spec	cify Yes or No	- 14. Rao	e - America	
0	or it		1 ☐ Never Married 2€ Married	1 Yes 2 If Yes, Give				Specify:		10011, 010.)			
00	Pai'.	by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates	:	10169	232 140	эрвину.			Specify	w Whi	.te
21215-0020	in 72 hours efter death with the Maryland "natural", or items 23s or 28s-f show ledical Examinat must be notified at	Completed	15. Decedent's E (Specify only highest gi	Education	16a.	Decedent's Usi (Give kind of w	al Occi	petion	t of working		16b. Kind of Bu	usiness/Ind	lustry
21	⊆ ⊈	pje	Elementery/Secondary (0-12)	College (1-4or	5+)	life. DO NOT	use retir	ed)	O WOINI	9			
		NO.	12	4		HOMEM	AKE	R			OWN H	OME	
b	be filed ntel Hygi d other event,	Be	17. Father's Name (First, Middle, Las	at)				18. Mothe	er's Neme	(First, Middle,	Maiden Sumam	1e)	
<u>a</u>	should b	To	THOMAS EDWARD	HARRIS				ETHE	L LE	E ARN	IOLD		
Maryland	short and A		19a. Informant's Name/Reletionship	(Type, Print)	19b.	Mailing Addres	s (Stree	at and Numbe	er or Rural	Route Numbe	er, City or Town,	Stete, Zip	Code)
	permit. Pages 1 and 2 should by Depertment of Health and Mente Important: If Item 27 is marked any injury or other traumatic and one.		KINNIARD ROWE	McKEE	214	4 SOUT	н м	ORRIS	ST.	. OXF	ORD, M	D216	54
Baltimore,	f He f He tem othe		20a. Method of Disposition			Disposition (Na y, crematory or				Date	20c. Location -		
5	age ent o t: #		1 ☐ Burial 2 ☐ Cremetion 3 [ 4 ☐ Donation 5 ☐ Other (Spec.		В				7 /	2/07	311113 00		
Ξ	it. P		21. Signature of uneral Service Lio	**	U.S. 1			DEMY ress of Fecilit		3/9/	ANNAPO	LIS,	MD
Ba	Dependent of the population of		11/10/11	71 10	1	Fello	WS,	Helfe	nbei	n, &	Newnam	Fun	eral Home
_			/ (annu/:/	Jun 1		200 S	out	h Har	risc	n St.	, East		MD 21601
			23a. Pert1. Enter the diseded, or cor shock, or heart failure. List only	nolications that cause y one ceuse on eech	ed the death. Do n line.	ot enter the mo	de of dy	ring, such es	cardiac or	respiretory e	rrest,		Approximete tntervel Between
١.	Physician					,						i	Onset end Deeth
	/Medical Examiner		Immediate Ceuse (Finel disease or condition	Gas	trointe	stinal	He	morr	hoar	>		1	1 clar
	LXUITIIICI		resulting In death)	0.	Due to (or es e c	onsequence of	:		)-				
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	ertificate be executed ling physician end se es the bunal-transit	Examiner	Sequentially list conditions,	b	Due to (or es e c								
Ö,	e exe		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury										
68760	hysic the b	edicai	thet initieted events resulting in deeth) Lest	С	Due to (or es e c	onsequence of)	:						
9 X	E 00	/Mec										1	
Bô	0 9 9	an/		d								<u>+</u>	
	death	sici	Pert II. Other eignificent conditions	contributing to deeth	but not resulting In	the underlying	ceuse g	iven in Pert I.		23b. Dld	tobecco use cor	ntribute to	the cause of deeth?
P.0	f the by th tache	Physician			_	, ,				10	Yes 2□ No	3□ Prot	pably 4% Unknown
	es that igned b	by F											
Ď	v requires been sign should be	p									en eutopsy		ere eutopsy findings
S	N D	et								репо	rmed?	con	eilable prior to mpletion of ceuse death?
Vital Records,	The iaw ete hes b pege 2 s	Completed									-		
a										10	Yes 2 No	1	Yes 2 No
₹	Physician: The this certificate ral director, peg	Be	25. Was case referred to medical exeminer?	Hospital:			0	thor:		(Check only o			
of	S .0 0	1°	1 Yes 2 No 27. Menner of Deeth	1 to Inpat		•	UA				dence 6 Oth		)
	ing F	0	1 Natural 5 ☐ Pending	28e. Dete of Inj (Month, D			28c. tnje We			dd. Describe i	how Injury occurr	red	
Si	Attending or death. ector: After by the fune	cat	2 Accident investigetion 3 Suicide 6 Could not l	ne -	ــــــــــــــــــــــــــــــــــــــ	М		Yes 2 1					
Division	or All after of Direction by	Certification:	4 Homicide determined	28e. Place of If	njury - At home, far etc. <i>(Specify)</i>	m, street, facto	ry, office	•	28	City or Tov	Street and Numb vn, Stete)	er or Rural	Route Number,
	urs e urs e rai	ပိ											
	Hose 4 ho Fune tely f	edicai	(Check only 2 Medical Exa	ysidien: To the best niner: On the basis	of examination end	death occurred For investigation	let the t n, in my	ime, date en opinion, deel	d plece, er th occurred	d due to the	ceuse(s) end me date end place, (	end due to	eted. the ceuse(s)
	To the Mospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	Med	UNO)	and makner s	tated.								
	5 × 5 0	Title	29b. Signature end title of end fier	/ / /	71			ise number			29d. Date signed		
			VV	I IN	IV		KE	5 0	00		June	28	1997
			30. Name end eddress of person whi	completed ceuse of	death (Item 23e) (	Type, Print)		11	1		, ,	,	
			W Bowerfind	MD -	death (Item 23e) (	110	sh	ns H.	opki	05 H	ospita	1	
	Sta	_	31. Date filed (Month, Day, Year)	32. Regist	trer's Signature						V		
	Registr	ar	JUL - 1	199/	Mar	- dell							

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_				iai yiaila i	Certificate of		1200	. No.	6. 1 to 7 1				
	Physici	an	Decedent's Neme (First, Middle, Last)				Data of Deeth     Month	Dey Yeer	3. Time of Death				
4	/Medic		Virgil Douglas McCray Sr.				June 17	, 1997	1339				
	Examir	ner	4a. Facility Nama (If not institution, give street and numbe Atlantic General Hospital	r)		4b. City, Town, or Li Berlin	ocation of Death	4c. County of Dee					
	Funeral			Aga (In yrs. lest bii			8. Date of Birth	Worceste					
	Funeral Director		013-16-1453 1™ 2□ F Usuel Residence of Decedant		Yrs. Months Days	Hours Min.	(Month, Day, )	16 Del	thplaca (Stata or Foreign buntry) aware				
	yiend		10a. Steta 10b. County	10c. City, Tow					10d. Inside City Limits				
	Merical States	ctor	Delaware Sussex	Frankf	ord				1 ☐ Yes 2 🔣 No				
4	2 5 E	Director	10e. Street and Number		10f. Zip Code		100	g. Citizan of Whet Co	ountry?				
4	23a		Rt. 2 Box 292		19945			USA					
Maryland 21215-0020	De ned within 72 hours enter deem with the merylend niel Hygiene. Ned other than "natural", or items 23a or 28a-f show event, the Modical Evantiner must be notified at	by Funeral	11. Marital Status  1 Nevar Merried 2 Married  3 Widowed 4 Divorced  12. Was Deceden Armed Forcas 1 Yes, Give Yeer or Detes	s? <b>X</b> No	13. Was Decedant of H tf Yas, specify Cube 1 ☐ Yas 2 🛣 No		ecify Yas or No- Rican, etc.)	14. Rece - Ame Bleck, Whit Specify:					
5-0	natur lical	Completed	15. Decedent's Education (Specify only highast grade completed)	16a	Decedent's Usuel Occup (Giva kind of work done	ation	ina 16	6b. Kind of Business	Industry				
121	then then	mple	Elementery/Secondery (0-12) College (1-4or	r 5+)	life. DO NOT use retired	1)							
12	other th	S	8 17. Fether's Nema (First, Middle, Last)	p	oultry worke		p (First, Middle, Me	oultry in	dustry				
-	B - 0 S	o Be	Joseph Henry McCray		and grant and an artist and a state of the s	Frances		ndan Sumama)					
ary	mari mari	To	19e. Informent's Neme/Reletionship (Typa, Print)	191	b. Malling Address (Street			City or Town, Stete.	Zip Code)				
Ž	aith e 27 is or tra		Hazel E. McCray		t. 2 Box 292								
ore,	of He rother		20e. Method ot Disposition	oom oto	ot Disposition (Neme of ory, cremetory or other plea	ce)	Dete 20	c. Location - City or	Town, Stete				
im	ant: H		1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from Stets 4 ☐ Donetion 5 ☐ Other (Specify)	a	ch Cemetery		5/21/97 F	rankford,	Delaware				
Baltimore,	permit regas I end 2 should be permit regas I end 2 should be important: If hem 27 is marked any Injury or other traumatic events.		21. Signeture of Funerel Solvice Licansee	2000	22. Name end Addre Watson Fu Millsboro								
			23a. Part1. Entar the disaasa, or complications thet cause shock, or haert teilure. List only one ceusa on each	ad tha death. Do				t,	Approximata Intervel Between				
	hysician /Medical						Onset end Deeth						
=	xaminer		Immediate Cause (Finel disease or condition resulting In deeth)  e. Chronic Heart Failure  Due to (or es e consequence of):										
3	sit a	Examiner	a b 73 9	5 C V	$\bigcirc$								
68760,	physicien end s the burief-transit	хал	Sequentially list conditions, if env, leeding to immediate	Due to (or as a	consequence of):								
68760,	siclen		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events										
687	g phys	edicai	resulting in deeth) Last	Due to (or as a	consequence of):								
		M/u	d										
O .	ed for	sicia	Pert II. Other significant conditions contributing to death	but not resulting in	n the underlying cause giv	en in Pert I.	23b. Did tob	acco use contribute	to the cause of death?				
I Records, P.O. Box	signed by the ettending d be deteched for use es	Physician/M	CA Prostate				1 Tyes	21 No 3 P	robably 4 Unknown				
JS,	signed bed	þ	CII										
Vital Records,	been si	Completed					24a. Wes an	ed?	Were eutopsy tindings aveileble prior to completion of cause				
Rec	hes t	dm							of death?				
	certificate rector, pag		25 Was seen reterred to modical				1 □ Yes	2.72 No	1 ☐ Yas 2 ☐ No				
Vision of Vita	s certi	To Be	25. Wes case reterred to medical examiner?  1 ☐ Yes 20 No Hospital: 1 ☐ Inpat	tient 2 ER/Ou	utpatient 3 DOA Oth	or	n <i>(Check only one)</i>	ca 6 □Othar (Spe	off A				
O L	er this		27. Menger of Deeth 28e. Dete of Inj	ury 28b.	Time of 28c. Injury		28d. Describe how		City)				
ior	eth. r: Aft	atio	1 ☑ Neturel 5 ☐ Pending (Month, D	Yes 2□No									
Division of	efter deeth. Director: After I in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Ir building, e	njury - At home, fa	arm, street, fectory, office		28t. Location (Stre City or Town,	et end Number or R Stete)	ural Route Number,				
۾ ۾	d le li												
Hoso	within 24 hours effer deeth.  To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis and menner s	of exeminetion en	e, deeth occurred et the tim nd/or investigetion, in my o	ne, dete end piece, pinion, deeth occurr	end due to the ceu ed et the time, dete	se(s) end menner es e end plece, end dua	s steted. I to the cause(s)				
o the	o the	Š	29b. Signature and title of certifier	teted.	29c. License	e number	290	I. Data signed (Mont	h, Dey, Year)				
	× F 0		Julan Juedo		CI	DODRO	35	6/20/0	77				
		-	30. Neme end addrass of person who completed cause ot	deeth (Item 23e)	(Type, Print)	0000							
			Gustavo A Mesto	DMa	The state of the s	26 /	Mele	bors.	DE 19964				
E	Sta Registr		31. Dete filed (Month, Day, Year) 32. Jegist	trans Signature	Cardall								

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State of Maryland / Department of Health and Mental Hygiene 97 2 1 2 9 8

Certificate of Death

						Ce	rtificate	OT	Death			Reg. N	lo.			
	Physici /Medi		Decedent's Name (First, Middle DOROTH)		AY	MARTIN			7		JUNE 2		1 <sup>9</sup> 997	Yeer	3. Time 1455	of Death
	Examir		4e. Fecility Name (If not institution Sacred Heart Hosp		u <i>mber)</i>				4b. City, Tow Cumbe		cation of Deet	h 4	c. County	of Deeth		
Ī	Funeral Director		5. Social Security Number 215-20-6609	6. Sex 1 □ M 2X□ F	7. Age (II	yrs. last birthday Yrs.	Months D	Year	If Under 2 Hours	4 Hrs. Min.	8. Date of Bir Month, De 09-Sep	th by Yea -25	7)	9. Birthp Coun Mary lo	lace (Stete try) Ind	or Foreign
Ī	r 28s-f show	tor	Usuel Residence of Decedent  10a. Stete 10b. County  Maryland Alle	gany		oc. City, Town or L Frostburg	ocation							1		City Limits
	th with the 23e or 28s	i Director	10e. Street end Number 8500	Martin Run	Road,	S.W.	10f. Zip Co	ode 153	12-			10g. C	itizen of V	Whet Cour	try?	
020	ter dee	by Funerai	11. Marital Status  1 □ Never Married 2 □ Mar  3 □ Widowed 4 □ Divorced	If Yes C	Forces?  2 No live		Was Deceden If Yes, specify	t of F Cub		in? (Spe Puerto	ecity Yes or No Rican, etc.)	)-	14. Rac Bled	e - Americ ck, White,	etc.	
Maryland 21215-0020	77 - 1	Completed	15. Deceder (Specify only higher Elementery/Secondary (0-12)		(1-4or 5+)	16e. Dece (Give life. Publish	dent's Usuel C e kind of work of DO NOT use i	ocup done retire	eation during most d)	of worki	ing			er Publi		
/land	d 2 should be filed within hand Mental Hygiene. 7 is marked other than traumatic event, the M	To Be	17. Father's Name (First, Middle, James C. Murray	Last)							(First, Middle,		an Sumem	ne)		
	ges 1 and 2 should be filed to f Health and Mental Hyg If Item 27 is marked othe or other traumatic event,		19e. Informent's Name/Relations John M. Martin	ship (Type, Print) SON			ing Address <i>(S</i> Irt <b>i</b> n Run Ro				burg		or Town, arylan		Code) 21532	-
Baltimore,	E C - >		20a. Method of Disposition  1		State	20b. Plece of Disp cemetery, cre ount Savage	matory or othe	r ple		0]	Dete			City or To	wn, Stete Marylo	an d
Balt	permit. Pa Departmer Important: any Injury once.		21. Signeture of Funeral Service	Licensee	1		2. Name and A Jurst Fune		_		ost Ave.,	Fros	tburg,	MD 2	1532	
	Physician /Medical Examiner	er	Immediate Ceuse (Final disease or condition resulting in death)  Due to (an an aconsequence of):												Approxim Intervel B Onset end	etween
κ 68760,	certificate be executed ding physician end use as the buriel-trensit	VMedical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest	b		to (or as e conse										
Box			Pert II. Other significant condition	d.	teath hut no	nt resulting in the I	inderlying caus	e ai	en in Pert I		23h Did	tobacc	o use co	ntribute to	the cause	of death?
P.O.	that the	y Physicial	COPI		Journ But III	or resulting in the	andonying dada	so giv			1 🗆		No			Unknown
Records,	requir	Completed by									24e. Wes	en eut ormed?	opsy	COL	ere eutops eilable prio apletion of deeth?	rto
ital F	sician: The law certificate has t director, page 2 s	Be Cor	25. Wes case referred to medica	I I					26 Place	of Death	1 Check only	Yes	No	1 [	Yes 2	□ No
ion of Vital	this el c	P 1 Yes 2 No Hospital: Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nurs							sing Hor	me 5□ Resi 28d. Describe	dence			()		
Division	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Plac	e of Injury - ding, etc. (S	At home, farm, st pecify)	reet, factory, o	ffice		2	28f. Location ( City or To	Street o	end Numb ite)	er or Rura	/ Route Nu	mber,
	ne Hospital n 24 hours ne Funeral pletely filled	edical	29a. Certifler (Check and 2) Modical one)	g Phyelctan: To the texaminer: On the tend me	e best of my pasis of exa nner stated.	minetion end/or in	h occurred et t vestigation, in	he tir	me, dete end pinlon, death	plece, e	end due to the ed et the time,	ceuse date e	(s) end me nd place,	enner es si end due to	eted. the ceuse	(s)
	2	Σ	29b. Signatury and Mislot certifie	n Hhu	thun		29c. L	E P	number 26-	33	3	29d. D	JUNE	20	Dey, Yeer)	
	4268		30. Name and address of person	OD S	of deeth	(Item 3e) (Type	PriClus	6	mo	Pa	21502	7				
	Sta	te	31. Date filed (Month, Day, Year)	197 462	Restaura to	Signature Lati		_								

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 1200 June Lelia Naomi Maddox /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 5. Societ Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Yeer) 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Deys Hours 1 M 2 F Months Director Yrs Feb.16 1921 Maryland 219-03-4493 76 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locetion 10d. Inside City Limits 1 Yes 2 □ No Director 288-1 Maryland Somerset Princess Anne 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8 Herns 23a 11158 Somerset Avenue 21853 U.S.A Completed by Funeral 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yés 2 No If Yes, Give Yeer or Dates: natural, or 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Black. intal Hygiene. ad other than "natura c event, the Medical E 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5+Teacher None 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Pages 1 and 2 should be nent of Health and Mental David Frank Collins Pearl Curtis 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 12 reportant: If Item 27 ny injury or other tr Wanda Turner (Daughter) 4310 Mary Ridge DR.Randallstown, Md. 21133 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) St. James U.M. Church Cem. Westover, Md. 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Stewart Funeral Home Bladys B. Stewart 821 West Rd.Salisbury, Md.21801 23a. Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart milure. List only one ceuse on each line. Approximate Intervet Between Onset end Death **Physician** /Medical Immediate Ceuse (Finet Concluse arrest diseese or condition resulting in death) MINS Examiner Myocardial Lymtin (Sugret) Physician/Medical Examiner MINY or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest buriel-tran YKS P.O. Box 68760. Due to (or es e consequence of): for use as the Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, þ 8 24b. Were eutopsy findings evailebte prior to completion of cause of death? Be Completed 24a. Wes en eutopsy performed? certificate hes 2 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1⊟Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this the funeral Dete of tnjury (Month, Dey Year) Certification: 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Naturel death. 1 Tyes 2 No s efter death 2 Accident 6 Coutd not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled in 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

2 Medicat Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner steted. 29a. Certifier Medical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) Smuld M. him 10 010688 30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print) 13 RMC 31. Dete fited (Month, Dey, Year) 32. Registrer's Signature State

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Tima of Death Month **Physician** MILDRED MANNO Μ. 1997 1000 June 18 /Medical 4a. Facility Nama (If not Institution, giva street end number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Aga (In yrs. last birthdey) Birthplece (State or Foraign Country) **Funeral** Months 1□M 2以F Yrs 15,1919 Director 176-16-6930 AUG. PA Usual Rasidance of Dacedant Pagas 1 and 2 should be filed within 72 hours aftar death with the Manyland nart of Heath and Mantle Ihygene. Intil if item 27 is marked other than "natural", or items 23s or 23s-f show any or other tranmal be nottined at any or other tranmatic event, has leading Exemples must be nottined at 10a, Stata 10c. City, Town or Location 10b. County 10d, Insida City Limits 1 Yas 2 No Directo MD WICOMICO **EDEN** 10e. Street and Numbe 10f. Zip Coda 10g. Citizan of What Country? 3709 GARDENDALE DRIVE 21822 Funeral U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Ricen, atc.) 14. Reca - Amarican Indian, Bleck, Whita, atc. 11. Maritel Status 1 ☐ Yas 2 ☒ No If Yas, Giva Yeer or Datas: 1 ☐ Never Married 2 ☐ Marriad 3altimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: WHITE à 3 Nidowed 4 Divorced Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) College (1-4or 5+) HOUSEWIFE 12 OWN HOME 17. Fethar's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Be PHILIP SMITH 2 AGNES GARVEY 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Coda) JUDITH A. GIUNTA 3709 GARDENDALE DR., EDEN, MARYLAND 20b. Place of Disposition (Name of cematary, cramatory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 X Burial 2 Cramation 3 Ramoval from Stete 4 Donardon 5 Othar (Specify) permit. Pagas Department of Important: If its any Injury or o CATHERINE CEMETERY MOSCOW, PA. 21. Signature of Furierel Sarvice Licensaa 22. Nama and Address of Facility BOUNDS FUNERAL HOME, 705 E. MAIN ST., SALISBURY, MD. Fart. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Intarval Batw Onset and Deeth Physician /Medical Immediata Causa (Final diseesa or condition rasulting in daeth) Athnoschotie aven coronary Examiner years Due to (or es e consequança of): Physician/Medical Examiner physician and the burist-transit Sequantially list conditions, if eny, leeding to immediata ceuse. Entar Undarfying Cause (Disaasa or Injury thet initieted avants rasulting in death) Last Due to (or es e consequance of) Box 68760, Due to (or es e consequence of): 8 990 Part It. Other significant conditions contributing to death but not rasulting in the undarlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No p 24b. Wara autopsy findings aveileble prior to complation of ceusa of death? Completed 24a. Wes an eutopsy performed? page 2 1 Yas 2 No 1 Yas 2 No certificate 88 25. Was cese rafarred to medicel axeminar? 26. Placa of Daeth (Chack only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 Yes 2 No 1 Inpatiant Certification: To 2 ER/Outpatient 3 DOA After this 28e. Data of Injury (Month, Dey Year) 27. Manger of Death 28h Time of 28d. Dascribe how injury occurred 28c. Injury et Work? 1 Neturel 5 Panding 1 □ Yas 2 □ No investigation 2 Accident after death Director: 6 Couid not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 3 Suicide 28f. Location (Straat end Number or Rural Routa Number, City or Town, Stata) 4 T Homicida b 24 hours a Funeral D Hospital 29a. Certifian 12 Certifying Phyelcten: To tha best of my knowledge, daeth occurred at tha tima, data and place, and due to the ceuse(s) end menner es steted. Medical (Check only 2 Medical Examitnar: On the basis of axaminetion and/or investigation, in my opinion, death occurred et the time, date and pleca, and due to the cause(s) and mannar stated. To the Within 2 To the 29b. Signatura and titla of certifig 29c. Licensa number 29d. Dete signed (Month, Dey, Year) 06/18/97 mo D 41721 30. Nema and addrass of person who complated causa of daath (Itam 23a) (Type, Print) 2 INDESIDE Dr. Salisbury Md 21801 32. Registrar's Signatura

DHMH 16 Rev 6/95

State

Registrar

JUN 1 9 1997

. The second sec

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

802 Roxbury Avenue

20b. Place of Disposition (Name of cemetery, crematory or other place)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Day 2 Month Year July 1997 12:02 AM 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 14506 North Bel Air Drive Allegany Bel Air If Undar 1 Yaar If Undar 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) 30-MOI-2/ 7. Aga (In yrs. last birthday) 9. Birthpiace (Stata or Foreign Days 1 □ M 2 K F Months Maryland 70 Vre 10c. City, Town or Location 10d Inside City Umits Das 2 No Allegany Bel Air 10e. Straat and Number 4506 North Bel Air Drive 10f. Zip Code 10g, Citizen of What Country? 21502-U.S.A. 12. Was Dacedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. ☐Yes 21 No f Yes, Giva 1□ Yes 2 No Specify: White lf Yes, Giva Yaar or Dates:

16b. Kind of Business/Industry

20c. Location - City or Town, State

21502-

Homemaker

18. Mothar's Nama (First, Middla, Maiden Sumame)

Cumberland Maryland

Bernadette Roonev

Date

19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code)

**Funeral** Director

**Physician** 

/Medical

**Examiner** 

Nell Jean Morley

5. Social Sacurity Number

Usual Residence of Decedent

1 ☐ Never Married 2 ☐ Married

3 Widowed 4 ☐ Divorced

Elementary/Secondery (0-12)

John W. Morley

20a. Method of Disposition

17. Father's Nama (First, Middla, Last)

William "Gus" Sweitzer

19a. Informant's Name/Relationship (Type, Print)

10b. County

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

216-22-6010

Maryland

11. Marital Status

12

10a, Stata

Director

Funeral

þ

Completed

Be

2

permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28s-f show any Injury or other traumstic avery

Baltimore, Maryland 21215-0020

Box 68760,

Division of Vital Records, P.O.

Physician /Medical Examiner

The law requires that the death certificate be axecuted burial-transit and attending physiclan for use as the buria deteched signed by ti peen s hes certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice In by 24 hours a completely within 2 To the To the

1 Burial 2 ☐ Cremation 3 ☐ Removal from State Frostburg Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 05-Jul-97 Frostburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John 7 Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not anter tha moda of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting In deeth) Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disaase or Injury that Initiated avants resulting in death) Last Physician/Medical Dua to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2€ No 3 Probably 4 Unknown oranies þ 24b. Were autopsy findings available prior to completion of ceuse of daath? Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medicel examiner? 26. Place of Deeth (Check only one) Hospital: 2 20 No 1 Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 29a, Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signatura and title of certifia 29c. License number 29d. Data signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who



Name/a/d address of person who completed <del>suse of death (them 23s) (Type,</del> Print) John N. Mehanna, M.D., 902 S<del>eton Drive,</del> Cumberland, Maryland 21502

0

RANCO HILL

State of Maryland / Department of Health and Mental Hygiene 97 2 1 3 0 2

					C	Certificate o	of Death		Reg. No.	1 2	1002	
	Dharaia		1. Decedent's Name (First, Middla, Li	,				2. Data of De	-	Vaar	3. Tima of Death	
	Physic /Medi		Volodimir N/N	M/N Nalbo	orczy	k		July	<b>2</b> <sup>ay</sup> .	1997	5:00a.m.	
8	Exami		4e. Facility Nema (If not institution, given	ve straat and number)			4b. City, Town, or	Location of Deeth	4c. Count	y of Deeth		
			7850 Port Toba			- VIII AV	Port To		Char			
1	Funeral			1□M 2□F	rs. last birtho	Months De		(Month, Da	th y, Yaar)	Cour		
	Director		212-62-0327 Usual Rasidance of Decedant	X 2	4			FEB.29	,1952	MARY	LAND	
	yland		10a. Stata 10b. County	10c.	City, Town o	r Location				1	Od. Insida City Limits	
	a-f si	to	MARYLAND CHAR	RLES		PORT TO	BACCO				1 ☐ Yes 2 ☐ No	
	or 28	Sire.	10e. Street end Number			10f. Zip Code			10g. Citizan of	What Cour	ntry?	
	23a unit b	Funeral Director	BOX 7850 PORT	TOBACCO RO	AD	2	0677			U.S.	A .	
	or dec	nue	11. Marital Status	12. Was Dacedent Ever in Armed Forcas?	U,S.	<ol> <li>Was Decedant of if Yas, specify C</li> </ol>	of Hispanic Origin? (Suban, Mexican, Puer	Specify Yas or No- to Rican, atc.)	- 14. Rai	ce - Amaric		
20	72 hours after death with the Maryland neturel; or Items 23a or 28s-1 show dical Examiner must be notified at	by F	1 ☐ Nevar Married 2 ☐ Married 3 ☐ Widowad 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yas, Give Year or Datas:		1 ☐ Yas 2 ☐	No Specify:		Specif	y:		
21215-0020	n 72 hours "naturel", adical Exp		15. Decedant's E		16a De	ecedant's Usuel Oc	cunation	1	16b. Kind of B	WHI		
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21	d within giene. r then	E	10TH	Collaga (1-4or 5+)		CARPENT	ER		SELF	EMPT	OYED	
pu	al Hygid	Bec	17. Fathar's Nama (First, Middle, Last	)	·			ma (First, Middla,				
yla	should be fund Mental I	10	STEPHAN NALBO	DRCZYK			MARIA	KARMA	CIK			
Maryland	CI W		19a. Informant's Name/Raletionship	(Type, Print)	19b. M	lalling Addrass (Stre	eet and Numbar or R	ural Routa Numbe	ar, City or Town	, Stata, Zip	Coda)	
	of Haalth I kam 27 i		AGNES L. NALE		Di est D	SAME AS						
Ö	Pages I nent of H unt: If its		20a. Mathod of Disposition  1 TyBurial 2 Cremetion 3		camatary,	isposition (Name of cramatory or othar p	place)	Data	20c. Location		OBACCO	
Baltimore,	permit. Page: Department of Important: If i any injury or once.		4 ☐ Donation 5 ☐ Other (Speci		r.IGN		H.CEMETE	RY 7 - 5	-97 MA	RYLA	ND	
Bal	permit. Departminity imports any injuice.		21. Signatura of Funerai Sarvice Lice		1	22. Nama and Add	drass of Facility D FUNERA	T. SERV	TCE			
		_	Michael	V. Tozmo	-el	T.A PT.A	TA . MARYT	AND 20	646			
			23a. Pert1. Enter tha disease, or com shock, or haart failura. List only	ona causa a aach lina.	eth. Do not	antar the mode of o	tying, such es cardia	c or raspiratory ar	rrast,	į	Approximeta Intarval Batween Onsat and Death	
	Physician /Medical		Immediate Causa (Final								Orisat and Doath	
	Examiner		disaasa or condition rasulting in daath)	a _Colon_Ca			etastasi	s to li	ver &	lung	gs	
Dua to (or as a consequance of):										1		
	The law requires that the death certificate be axecuted ate has been signed by the attending physician and page 2 should be detached for use as the bunat-transit	Examiner	Sequentially list conditions.	b. — Dua to	(or as a con	sequance of):						
ő	e axe dan a urial-		Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaase or injury							i		
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Box	that the death ceined by the attendir	Physician/		- Marine				1				
0	the d	hysi	Part II. Other significant conditions of	contributing to deeth but not r	asulting In th	e undarlying ceusa	givan in Part I.				the causa of death?	
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Records,	v requires been sign should by	Da Da							an autopsy		ara autopsy findings	
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0 0	ding Phy h. After thi funeral		27. Mannar of Death  1 Natural 5 Pending	28a. Data of Injury (Month, Day Year)	28b. Tim	a of 28c. Ir	njury at Vork?	28d. Dascribe I	now injury occur	red		
sio	Attending ir death. actor: After by the fune	catl	2 ☐ Accidant Invastigatio	n	☐ Yas 2 ☐ No							
Division	i or Attendi aftar death. Director: A J in by the fu	Certification:	4 Homicida datarmined	28a. Place of injury - At building, atc. (Spe	homa, farm.	, straat, factory, offic	08		28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)			
	pitai ours a erai I		29a. Cartifiar Certifying Pt	yaiclan: To tha best of my k	nowledge d	noth occurred at the	time data and place	and due to the	anuan(a) and m	20001 20 0	totad	
	24 h 24 h Fun letely	edical	(Check only 2 Madical Examone)	niner: On the basis of axami and mannar steted.	nation end/o	r invastigation, in m	y opinion, daath occu	urrad at tha tima,	data and place,	and dua to	tha causa(s)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signeture end title of certifiar	1		29c. Lica	ansa number		29d. Data signe	d (Month,	Day, Year)	
			* Koure	7. 10	Uhn	D28	8352		July 2	2, 19	997	
			30. Neme end eddrass of person who	complated ceusa of daath (it	am 23a) (Ty	pe, PrInt)						
			Krishan Mathur			Box 2729	9, La Pl	ata, MI	206	16		
	Sta	-	31. Data filed (Month, Day, Year)	32. Registrar's Sig	natura					0		
	Registr	ar	JUL 0 3 19	97 John dan	ouarta	Mall						

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year ALICE E. NEWMAN 5:15 A.M. 28 1997 Vune /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** cumberland Nursing Home cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2🛛 F Months 215-20-6937 89 Yrs. Director Oct. 3,1907 Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examense must be notified at Allegany Cumberland 1DYes 2 No maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 135 N. Machanic St. 21502 USA APTS. Funeral 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ■ No if Yes, Give Yeer or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ■ No by 3 Widowed 4 □ Divorced Black should be filed within 72 hours nd Mental Hygiene. marked other than "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SOLPS Clark 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 end 2 should be filk Depertment of Health end Mental Hy Important: If Itam 27 is marked oth any Injury or other traumatic evam Annie Powell Harry Vance Males 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AUP, CUM benland, Md, 21502

Date 20c. Location - City or Town, Stete VUNE Ashby Pine 416 20b. Place of Disposition (Name of cemetery, crematory or other place)

SUNSET Memorial Pank 2, 1997 Cumber land, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Errost a. Riby, A., Leasure-stein, Twc, 230 Balt, wore lave.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate **Physician** /Medical Immediate Cause (Final Carcinoma 1 Year. diseese or condition resulting in death) Examiner Due to (or as a consequence of) Examiner buriel-trensit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): end P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attanding Physician: 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Natural n 24 hours efter deeth.

The Funeral Director: All pletely filled in by the fu deeth. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 033280 June 28, 1997 4 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) me 625 KANT AVE, CUM barland, Md. 21502 Gupta, M.D. State

**DHMH 16 Rev 6/95** 

Registrar

State of Maryland / Department of Health and Mental Hygiene

	Director
Baltimore, Maryland 21215-0020	permit. Peges 1 and 2 should be filed within 72 hours effer death with the Meryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 900ce.

**Physician** /Medical Examiner physicien end s the burial-transit The law requires that the death certificate be executed P.O. Box 68760. signed by the Records, certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Ennaral Director: After this certifica stelly filled in by the funeral director, t To the Hospital o within 24 hours eff To the Funaral Di completely filled in

Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month NOVAK PAIGE 1997 9:55 AM June /Medical 4a. Facility Nama (If not institution, giva straet and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Georges Doctors Community Hospital Lanham If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Yeer) 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foraign **Funeral** 1□M 2K F Yrs. 77 216-36-6549 VIRGINIA 05-19-1920 Usual Rasidance of Dacedan 10a Stata 10b County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No Director GLEN BURNIE MARYLAND ANNE ARUNDEL 10e. Street and Numbe 10f. Zip Coda 10g. Citizan of What Country? 21061 U.S.A. Funeral 316 6TH N.E. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No 11 Marital Status Was Dacedant of Hispanic Origin? (Spacify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 1 □ Naver Married 2 □ Married 1 ☐ Yas 2 ☐ No Specify: þ Specify: WHITE 317 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completad) 16b. Kind of Businass/Industry College (1-4or 5+) Elamentery/Secondary (0-12) CLERICAL D.M.V. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surname) Be LAURA MAE CORVIN **GEORGE** WASHINGTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 290 BOWIE SHOP ROAD, HUNTINGTOWN, MARYLAND 20639 DORIS AILEEN SHEER (DAUGHTER) 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Bunal 2 □ Crametion 3 □ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Spacify) GLEN HAVEN MEMORIAL PARK 6/30/97 GLEN BURNIE, MD 21 Signatura of Funaral Sarvice Licenses 22. Nama and Address of Facility
SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MARYLAND 21061 her 23a. Part1. Entar the disaasa, or complications that dayse the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Intarval Between Onsat and Deeth Immediate Causa (Final disaasa or condition rasulting in death) Deptice mia to (or as a consaquance of) Rilo Saquantially list conditions, if any, laading to immediate causa. Entar Underlying Cause (Diseasa or Injury that initiated events resulting in daath) Last Due to (or as a consequence of): Physician/Medicai Dua to (or as e consaquance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 Unknown 1 Yes 2 100 þ 24a. Was an eutopsy performad? 24b. Wara autopsy findings available prior to complation of causa of daath? Completed 1 ☐ Yas 2 ☐ No 1 Yas Be 25. Was casa rafarred to medical axaminer? 26. Plece of Death (Check only ona) Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yas 2 No Certification: To Inpatient 2 ER/Outpatiant 3□ DOA 27. Mannar of Death 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 2 Accidant 5 Pending Invastigation 1 ☐ Yas 2 ☐ No 3 Suicida 6 Could not ba determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, straat, factory, office building, atc. (Spacify) 4 I Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifian Medicai 29b. Signatura and title of certifiar 29c. Licansa numbar 29d. Data signad (Month, Day, Yaar) D16410 June 27, 1997 30. Nama and address of parson who amplited car of daath (Item 23a) (Type, Print) 7500 Hanover Parkway, Suite 105, Greenbelt, MD Gabriel Jaffe, MD

State Registrar

31. Data filed (Month, Day, Year)

JUL 01 1997

32. Ragistrar's Signature

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			Certificate of Death Reg. No.											
Discontation			Decedent's Neme (First, Middle, Last)							2. Dete of Deeth			3. Time of Death	
Physician /Medical			Julia Maxine Oliphant						June	28, 199	Yeer 7	18:	40 pm	
	Examir		4e. Fecility Neme (If not institution, give street end number)				4b. City, Town, or Location of							
			6945 E. New Ma	rket, Elwo	od Rd.			Hurlo	ck	Dorch	nester	2		
	Funeral			Sex 7. Ag	e (In yrs. lest b		nder 1 Year			rth	9. Birthp	lace (Ste	te or Foreign	
	Director		422-14-2487	1□M 2∏F	74	Yrs. Mon	ths Deys	Hours	July 2	8,1922	Miss			
2	P ,		Usual Residence of Decedent											
	ehov		10e. Stete 10b. County			vn or Location					1		e City Limits	
	Ba-f	Director	Md. Dorch	ester	Hur	lock						1 🗆 Y	res 2X☐No	
	E S S	- Si	10e. Street end Number			10f.	Zlp Code			10g. Citizen of	What Coun	itry?		
	23a	62	6945 E. New Mark	et Elwood	Road		21643			USA	š.			
	en a	Funeral	11. Maritel Status	12. Wes Decedent Armed Forces?	Ever in U,S.	13. Wes Do	ecedent of h	lispanic Origini an, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)		ce - Americ		l,	
0	or it		1 Never Merried 2 Married				s 25 No	Specify:	20.101.10411, 0.0.,	Specia		olo.		
8	72 hours efter deeth with the Meryland netural; or Items 23s or 28s-f show dical Examiner must be notified at	d by	3 ☑ Widowed 4 □ Divorced	Yeer or Detes:			- X			Specii	y.	Whit	e	
5	72 h	Completed	15. Decedent's (Specify only highest of		166	Decedent's U	Jsuei Occup work done	petion duning most of d)	working	16b. Kind of B	usiness/Inc	dustry		
12	filed within Hygiene. Ither then out, the Me	dr.	Elementery/Secondary (0-12)	College (1-4or				d)						
2	filed within Hygiene.	3	12		H	omemake	er			Hon				
n n	d out	To Be	17. Father's Neme (First, Middle, La						Neme (First, Middle					
-	2 should be food and Mental is marked of raumatic even		Odis M. McCutche					Cora	Belle McN	eal McCu	tcher	1		
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	s 1 end 2 street Heelth er treet other treet		Robert L. White,	Jr.; Frie				larket,	Hurlock,					
0	Pages 1 e		20a. Method of Disposition  1X Buriel 2 □ Cremetion 3	☐Removel from State	20b. Plece o	of Disposition ( ery, cremetory	Neme or or other ple	ce)	Dete	20c. Location	- City or To	wn, State		
Baltimore,	Pag ment ant: ury		4 ☐ Donetion 5 ☐ Other (Spec		St. S	Tephens	s Ceme	tery	7-1-97	Delmar	, De.	,		
a	permit. Pages Depertment of Important: If it any injury or once.		21. Signeture of Funerel Service Lic	ansee	,			ss of Fecility	_					
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	' <b>-</b>		23a. Part1. Enter the diseese, or co shock, or heert feilure. List on	mplicetions thet cause	the deeth. Do	not enter the	mode of dyle	ng, such es car	diac or respiretory	errest,		Approxim	mete	
	Physician		STOCK, OF TIDENT TOTAL CLIST OF	y one couse on eour n	110.							Onset er	Between nd Deeth	
鑫	/Medical		Immediate Cause (Final disease or condition resulting in death)  Browdiageuc CA											
	Examiner		resulting in deeth)  Due to (or see consequence of):											
	D #	ner					,							
onteo	ficete be executed physicien and is the burlat-transit	Sequentially list conditions, if any leading to immediate the cause Enter Indentions												
0	e exe		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury								į			
68760,	ysic he bu	Medical	thet initieted events resulting in deeth) Lest	C. Due to (or es e consequenca of):										
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	ras tha igned be det	by I												
quira ouid t	should bean significant of the state of the					24e. Wes en eutopsy performed?				24b. We	24b. Were eutopsy findings evellable prior to			
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of Vital Records, Physician: The law requires the	The la	E							1.	Yes 2□No	1[	Yes 2	2□ No	
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Division	Attending in deeth.	tho	1 ☑Neturel 5 ☐ Pending 2 ☐ Accident investigeti		oth, Day Year) Injury Work?			EX	Expired					
18	or Attendi efter deeth Director: A d in by the f	fice	3 Sulcide 6 Could not be 28e. Pleca of Injury - At home, for			erm, street, fed	ctory, office		28f. Location	28f. Location (Street end Number or Rural Route Number,				
ā	3 1 3 8	Certification:	4 Homicide determined building, etc. (Specify)					City or Town, State)						
	the Hospital thin 24 hours the Funeral mpletely filled													
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	To the within : To the comple	M	29b. Signeture end title of cartifier				29c. Licens	e number		29d. Dete signe	d (Month,	Dey, Yea	r)	
			) (BL)				Oir	100 167	5	1/25	100			
	~	}	30. Neme end eddress of person who	completed cause of	eeth (Item 23e)	(Type Print)	010	co tre		6/00	11			
	8		MARYIC	2ANAW	1 M D	)				. –				
	Sta	te	31. Dete filed (Month, Day, Year)	32. Raraistr	er'a Signature	0								
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**DHMH 16 Rev 6/95** 

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death 3. Time of Death **Physician** Month Yeer PATTERSON 97 ANDREW PALMER .06 17 /Medical 1015 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY
If Under 24 Hrs. WICOMICO If Undar 1 Yaar 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpiaca (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Yrs. Director 218-27-4499 Maryland 01-08-90 Usuai Residence of Decedent e filed within 72 hours efter death with the Maryland al Hygiene.

other than "naturel", or items 23s or 28s-1 show 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "naturel", or items 23a or 28a-f shor treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Wicomico Allen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25505 Collins Wharf Rd. 21810 USA Funeral 12. Wes Decedant Evar In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) Rece - Amarican Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Yeer or Detes: 1 X Navar Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 A No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Student permit. Pages 1 and 2 should be file.
Depertment of Heelth and Mantal Hygi Important: If Item 27 is marked other any Injury or other traum-17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surneme) Mark Patterson Palmer Sarah Fiddler Elizabeth 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) Mark P. Palmer/Father 25505 Collins Wharf Rd., P.O. Box 43, Allen, MD 21810 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Ramovel trom Stete 4 ☐ Donetion 5 ☐ Other (Specify) Allen Cemetery 6/20/97 Allen, MD 21. Signatora of Funaral Service Licenses 22. Nama and Address of Fecility
Holloway Funeral Home M01051 Chompson 501 Snow Hill Rd., Salisbury, MD 21804 larro 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart tellure. List only one cause on each line. Approximeta Intervel Between Onset end Deeth **Physician** /Medical Immediete Cause (Finel disaese or condition resulting in deeth) ASPHYXIATION Examiner Due to (or es e consequenca of): Examiner physician and the buriel-transit Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceusa (Diseese or Injury that initiated events rasulting in deeth) Last Dua to (or as a consequence of): Physician/Medical the Dua to (or as a consequenca of) esn ò signed by the a P.0. Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Records, should 24a. Wes en eutopsy performed? 24b. Were eutopsy tindings available prior to Completed completion ot cause of deeth? pega 2 has 1 Yes 2 No 1 ☐ Yas 2 ☐ No this certificate Division of Vital Attending Physician: funeral director, 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) examiner? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 0 28e. Dete of Injury (Month, Dey Year) Certification: 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Dascribe how injury occurred or Attending Patter death.

Director: After the 1 Neturel 5 Pending ROTATING SWING ENTANGLED 1 ☐ Yes 2X No 2 Accidant 3 Suicida investigation 06-17-97 0930 CORD ON ROPE 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, tectory, office building, atc. (Specify) filled in by 4 Homicide 24 hours a 3311 ALLEN RD Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, and due to the cause(s) end menner es steted. To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pieca, end due to the cause(s) end menner stated. 29b. Signature and title of cartifier 29c. License number 29d. Dete signed (Month. Dav. Year) Julia 06-17-97 D.M.E. D03599 30. Name and elidress of person who completed cause of deeth Item 23a) (Type, Print) BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY MD 21801 32/Registrat's Signeture State

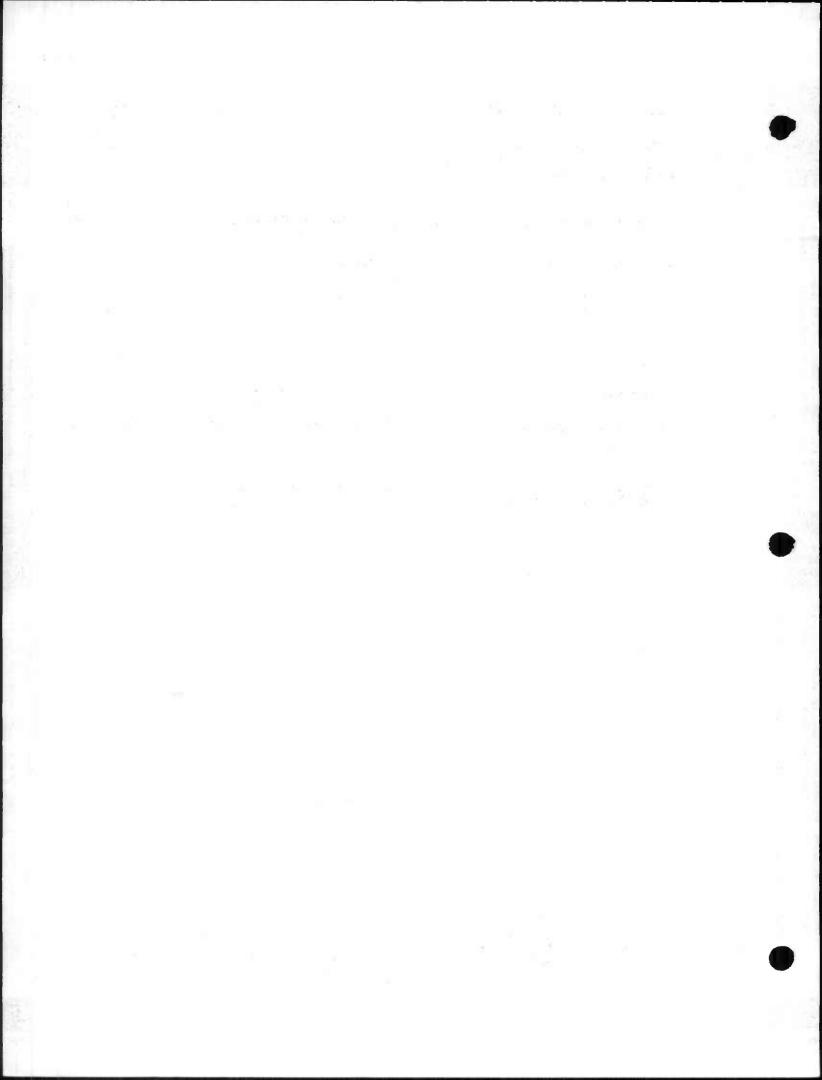
DHMH 16 Rev 6/95

Registrar

10-10-10 Section 1 STATE OF THE STATE Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 2 1 3 0 7

			Ce	ertificate of Death	Reg. No.	57 21001
			Decedent's Name (First, Middle, Last)		2. Date of Deeth	3. Time of Death
	Physici		WILLIE PALMORE		Month Day	97 10.13 AM.
	/Medic Examir		4a. Fecility Name (If not institution, give street end number)	4b. City, Town, or I	ocation of Death 4c.	County of Deeth
			DGH, Campudge	Course	lex.MN &	Jackeder
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthda)	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	9. Date of Birth (Month, Dey, Year)	9. Birthplace (Stete or Foreign Country)
	Director		263-03-7588 1AM 20F 93 Yrs.	Working Day's Hours Will.	1-6-0	
	P .		Usual Residence of Decedent	141		
	ahov ahov		10e. State 10b. County 10c. City, Town or I			10d. Insida City Limits 1    1    Yes 2 □ No
	M Page	5		rnish Drive Cambi	-	
	with the Maryland a or 28a-f show Lbs notified at	Director	10e. Street and Number	10f. Zip Coda	10g. Citi	zen of What Country?
	ath y	E	704 Cornish Drive	21613	USA	
	virs after death with the Marylai all, or thems 23s or 28s-f show Examinar must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces?	<ul> <li>Wes Decedent of Hispanic Origin? (S ff Yes, specify Cuben, Mexican, Puert</li> </ul>	pecify Yes or No- o Rican, etc.)	14. Race - American Indien, Biack, White, etc.
20	hours after tural, or its at Examina	by F	1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify:
21215-0020	2 3 2	b	100101001	edent's Usual Occupetion	40h Vi	Black
15	n 72 net	Completed	(Specify only highest grade completed) (Giv	re kind of work done during most of wor DO NOT use retired)	king 100. Kii	nd of Business/Industry
212	than the	E	Elementary/Secondary (0-12) College (1-4or 5+)			Farming
	Hyg Other	Be C	3rd Farm 17. Father's Name (First, Middle, Last)		ne (First, Middle, Melden	
Maryland	p and s	To B	Unknown	Unknow	n	
ar <sub>Z</sub>	shou and M a mar aumet	-		iling Address (Street end Number or Ru		r Town, Stete, Zip Code)
Ξ	and 2 should be file leith and Mental Hy, 27 Is merked othe er traumetic event,			Cornish Drive, Car		
e,	는 문화 등		20a. Mathod of Disposition 20b. Place of Disposition	position (Neme of emetory or other place)		cation - City or Town, Stete
Baltimore	Page ant o ny or		T Dunar 2 Micromotion 3 Linemoval from State	L CREMATON	7/3/97 0	SVER DEL
書	ermit. Pa Repartment mportant: my injury 8058.			22. Name and Address of Facility	7-1.	WOR DEC
m	Deg me			Bennie Smith Funera		. 01/01
		$\vdash$	23a. Pekt Linter the disease, or complications that caused the death. Do not e	onter the mode of dying such as cardied	ton, Marylar	Approximate
	Physician		shock, or heart tailure. List only one cause on each line.	mor the mose of dying, each as salend	or respiratory errost,	Intervel Between Onset and Death
<i>)</i>	/Medical		Immediate Cause (Final	41 .		• 1
	Examiner		disease or condition resulting in death)  a. Verticellar or	ky thrug		25 mits
	TIBLE!	Jer	Due to (or as a cons	equence or):	Alana	1/2
	rtificate be executed ng physicien and es the buriel-transit	Examiner	Sequentially list conditions.  b. Dua to (or es a cons	equenca of):	of acous	many years.
oʻ	exe en ar		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury			
68760,	ite be iysicii	Medical	that miliated events	equence of):		
	# D 0	Jed	resulting In death) Last			A PAGE
Box	eeth cer ettendir I for use	an	d			
	deer ne ett ed fo	Physician/	Pert II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part f.	23b. Dfd tobacco	use contribute to the cause of death?
P.0	res thet the de signed by the e be deteched t	2hy	· A.A. · O · O -	A	1 X Yes 2	□ No 3 □ Probably 4 □ Unknown
	gned be de	by	chance Amal Julilla	llan	/	
Records,	The lew requires thet the deeth ce ste hes been signed by the ettendii page 2 should be deteched for use		Paris		24e. Wes an eutop performed?	24b. Were autopsy tindings available prior to
900	hes be	Completed	Keumana		ponomio	completion of cause of death?
Œ	The I	E O			1 □ Yes 2,6	ÑNo 1□Yes 2□No
Vital		Be	25. Was case reterred to medical	26. Place of Dea	th (Check only one)	
<u>_</u>	E 10 10	To	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	ent 3 DOA Other: 4 Nursing H	ome 5 ☐ Residence 8	B □Other (Specify)
n of	ding Phy h. After this funeral	- 1	27. Manner of Death 1 Naturai 5 □ Pending 28a. Date of Injury (Month, Dey Year) Injury		28d. Dascribe how injur	y occurred
0	Attending or death. ector: After by the fune	atic	2 Accident Investigation	M 1 Yes 2 No		
Division	il or Attend efter death Director: A d in by the f	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be datermined  28a. Placa ot Injury - At home, farm, s building, atc. (Specify)	traet, tactory, office	28f. Location (Street end City or Town, Stete)	d Number or Rurel Route Number,
	tal or at Dira	Se				
	To the Hospital or / within 24 hours efter To the Funeral Director Completely filled in b	edicai	29a. Cartifier (Check only 2 Medical Examinar: On the basis of examination and/or i	th occurred at the time, date and place	, and dua to the cause(s)	and mannar as stated.
	To the h within 2, To the F complet	Med	erg manner stated.			
	To wit	-	29b. Signature and fills of certifier  M · D	29c. License number		e signed (Month, Dey, Year)
			-thank Mil	D-475	20 61	30/97
			30. Name and addless of person who completed cause of death (Item 23e) (Type	e, Print)		
				AURORA STRE	ET, CAMBR	IME, MD21613
	Sta Registr		31. Date filed (Month, Dey, Year) 32. Registrar's Signature			



#### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97

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	Funeral		5. Social Security Number	6. Sex	7. Aga (In	yrs. last birti	hday)	If Under 1 Year			8. Data of Bin (Month, Da	th Voorl	9. Birth	pleca (Stata or For	aign
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nd	T of H	Be	17. Fether's Neme (First, Middle, L						18. Moth	er's Nam	e (First, Middla,	Maidan Suman	10)		
a	should be filed within and Mentel Hygiene. marked other then metic event, the Mentel the	P	Luther Curtis	Powell						Amy	Cramer				
Maryland		ľ	19a. Informent's Name/Ralationsh	p (Type, Print)		19b.	Mailing	Addrass (Street	and Numb	er or Rur	al Routa Numb	er, City or Town,	State, Zip	Coda)	
			Irva S. Powell/	wife		23	0 S	t. Mark	Way	Wes	stminste	er, MD 2	21158		
ē,	ta He		20a. Mathod of Disposition		20			ition (Nama of atory or othar pla			Data	20c. Location			
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Baltimore,	permit. Peges 1 end Depertment of Heelth Important: if item 27 any injury or other to once.		21. Signature of Funeral Service L	-			_			1	<i>'</i>		•		
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7	Physician												1	Onset and Death	
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89	phy s the	n/Medical	rasulting in death) Lest		Dua ti	o (or as e co	onsequ	ance of):							
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B		Clar													
Ö	the d	Physicia	Part II. Other significant condition	s contributing to	death but not	rasulting in	tha und	darlying cause giv	an in Pert	i.	23b. Dld	lobacco use co	ntribute to	the cause of dea	ith?
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of			27. Manner of Death	28a. Deta	a of Injury	28b. Ti	,			asing no		now injury occur		y) traiciti c	10116
on	h. After funer	to	1 ■Natural 5 □ Panding	(Moi	nth, Day Yea		jury	28c. injui Woo	rk? Yas 2□	No		,,			
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-			30. Name and address of person w	no complated cau	10,000,00		Гуре, Р	rint)							
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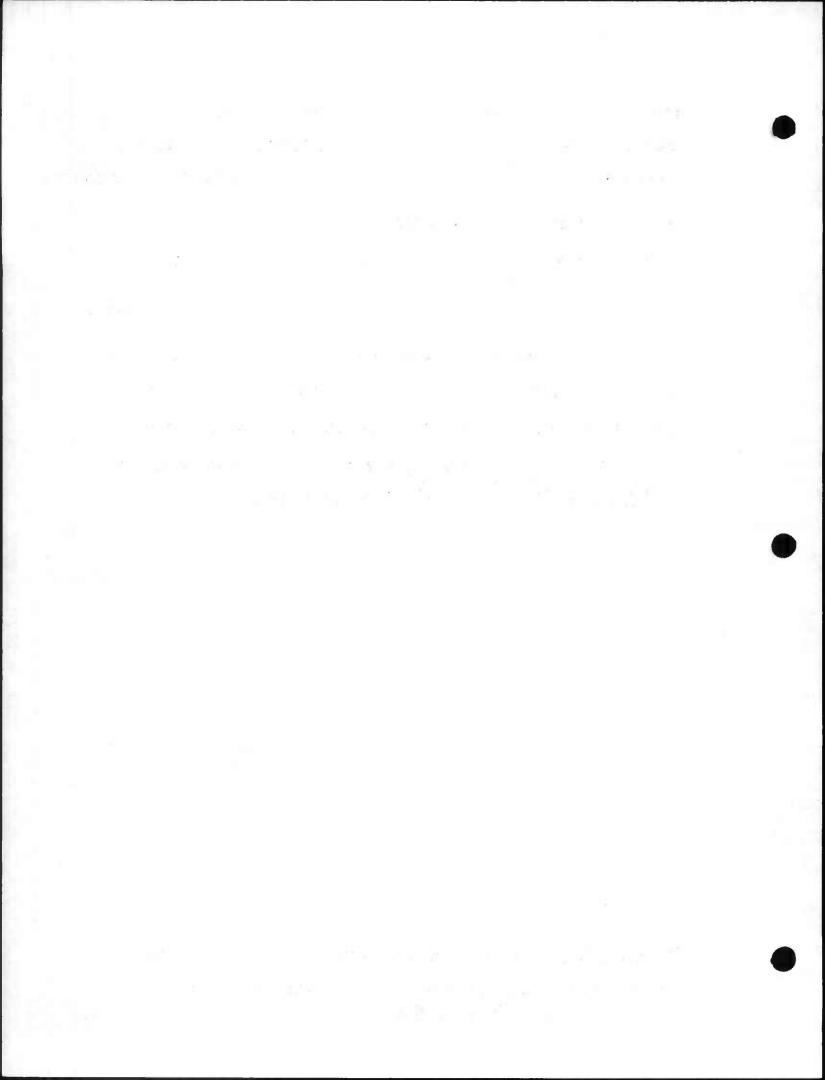
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State of Maryland / Department of Health and Mental Hygiene

							Ce	rtificate	of L	Death			Reg. No.				
			1. Decedent's Name	e (First, Middle, Le	est)							2. Date of De	eeth			3. Time of Death	_
	Physic		GEORGI	E	EDWA	RD	POL	L.EK				June	and Day	190	27	2059	
	/Medi Exami		4e. Fecility Neme (f				101	DD.K	4	b. City, To	wn, or L	ocation of Deal	1	County of E	Deeth	2031	-
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-	Funeral		5. Social Security N			. Age (In yrs.		if Under 1 Y	rear	if Under			rth			ace (State or Foreign	m)
п	Director		204-28-5		1⊠M 2□F	59	Yrs.		eys	Hours	Min.	8. Date of Bi (Month, De March 1	3 103	Q De	Count	ace (Stete or Foreig ry) rlvania	11
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	ahow		10a. Stete	10b. County		10c. Cit	y, Town or Lo	ocation							10	d. Inside City Limits	3
	Man	P	Maryland	Wicomi	ico		Ede	n								1 ☐ Yes 2 ☑ No	)
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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 2 1 3 1 0

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State of Maryland / Department of Health and Mental Hygiene 97

						Cert	tificate of	Death		Reg. No.				
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	Examir		4a. Facility Name (If not institution, giva	street and numbar)				4b. City, Town, o	r Location of Daath					
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			84.	KUDRINI/	W			116595	75	6.	50.	71		
			30. Name and address of person who co	ompleted cause of death (ite	m 23a) (	ype, P	rint)	D AVENU	1 1	) )	MA	٥.		
			MICHAEL CROWL			1	DUEWIL	U ITVENU	i h	ASTON,	1.117	211	601	
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	A		1. Decedent's Nam	ne (First, Middle	, Last)								2. Date (			Vaar	3. Time of I	Death
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7	/Medi Examii		4e. Fecility Neme (				01.				4b. City, To	wn, or L			4c. County		1.00	CILI
	LAGIIII	101	137 1	Lee Driv	20						Ann	apo1	ie		Anne	e Aru	ndel	
-	Francis		5. Sociel Security N		6. Sex	7. Age	(In yrs. lest b	irthday)	If Unde	r 1 Year				of Birth				Foreign
	Funeral Director		578-22-43		1√2 M 2□	E .	74	Yrs.	Months	Deys	Hours	Min.	8. Dete (Mont	h, Dey,	Yeer)		ece (State or	
	Director		Usual Residenca o		11		/ 4						Oct	T T	1922	wasn	ington	, D. C.
	and w		10a. Stete	10b. County			10c. City, To	wn or Lo	cation							1	Od. Inside City	/ Limits
	Aary	ō			. 1	,		A	. 1								1 ☐ Yes	
	the 1	Director	MD 10e. Street end Nu		Arunde	1		Ann	apol:					46	- ON (1)			
	F 9 8								101. 21	Code	1/02			10	g. Citizen of V			
	ath 23	ral		Lee Dri							1403				Unite			
	rurs after death with the Manylar al', or Items 23a or 28a-f show Examiner must be multiped at	Funeral	11. Maritel Status		Arme	Decedent E d Forces?		13. \	Vas Dece f Yes, spe	dent of cify Cul	Hispanic Ori ban, Mexicar	igin? (Sp n, Puerto	ecify Yes of Rican, etc.	or No-		e - Americ k, White,		
20	or i		1 Never Marr		If Yes	es 2 □ No s, Give			I □ Yes	2 <b>K</b> [X]0	Specify:				Specify			
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5	be filed within 72 hotel Hygiene. d other then "netui	Completed	(Spec	<ol><li>Decedent cify only highes</li></ol>	s Education t grade comple	ted)	16	Give	lent's Usu kind of wo	el Occu ork done	ipetion e during mos ed)	t of work	ing	1	6b. Kind of Bu	siness/Inc	lustry	
2	within ene. than	du	Elementary/Seco	ondery (0-12)	Colte	ge (1-4or 5+	+)	life. L										
N	ed w ygiel f, ft	S	12						Mach	inis	T				Print		lant	
nd	Hot How	Be	17. Father's Neme	(First, Middle, L	.ast)						18. Mothe				leiden Sumem	ie)		
<u>yla</u>	should be filed within 72 hours after death with the Maryland nd Mentel Hygiene. "retural", or Items 23s or 28s-f show marked other than "natural", or Items 23s or 28s-f show imatic event, the Wed call Examined.	2	Karl Bei	nton Re	ctor, S	r.						Ka	te Mu	iell	er			
Maryland 21215-0020	0 0 0		19a. Informent's N			)	19	b. Meilir	g Addres	s (Stree	et end Numbe	er or Rui	el Route N	lumber,	City or Town,	Stete, Zip	Code)	
≥.			Kent B.	Rector	(Son)			137	Lee :	Driv	e An	napo	lis,	Mar	yland :	21403		
re	ite He		20e. Method of Dis				20b. Plece cemet	of Dispo	sition (Ne	me of	ece)		Date	2	Oc. Location -	City or To	wn, State	4-1-
E	Pege ent c			☐ Cremetion 5 ☐ Other (Sp		rom State	Lakem	ont	Memo	rial	Gard	ens	July	2	1997 Da	avids	onvil1	e, MI
Baltimore,	permit. Peges 1 and Depertment of Health Important: If Item 27 any Injury or other tr once.		21. Signature of Fig.			2 -								1				
B	permit. Depertr Importa any Inje		. //			1	1//	1,	-		c 01	John	м.	layı	or Fun	eraı	Home,	Inc.
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		. 1	23e. Pert1. Enter t shock, or hea	ine disease, or a	only one ceuse	on each line	ine deeth. Do e.	not ent	er the mo	ne or any	ring, such es	cardiac	or respiret	ory erre	st,		Approximete Intervel Betw Onset end Do	een
	Physician /Medical			·=:-		0										1	. 1	oou i
7	Examiner		Immediate Ceuse disease or condition resulting in death)	on	θ	HSF	PIRA	TIO	N	he	uma	32	a			1	4wh	4
		ایا	resulting in death)				Due to (or es				15			1 .				
	pe #s	Examiner			<b>b</b>	Par	kuns	or	ISV	n	/1	)en	reco	tro	i	1	341	2
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9 X	certificate be executed uding physician and use as the buriel-transit	/Me				HY	PER	PI	TRV.	+11	+ 413	110	218	M		į,	5 40	ans
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	requires that the death seen signed by the atter hould be detached for u	Physician	Part II. Other signif	ficent condition	s contributing	to death but	not resulting	In the ur	nderlying	ause g	iven in Pert I	١.	23b.	Did tol	Dacco usa col	ntributa to	the causa of	death?
P.0	by the	h'	Dra	10000	^									1 ☐ Ye	s 2 No	3 ☐ Prot	ably 4 U	Inknown
	es that igned t	by	ello	rescu														
Division of Vital Records,	v require been sig												24a.	Wes er	eutopsy	24b. We	ere eutopsy fir eilable prior to	ndings
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Æ	0 - 0	E												1□Ye	s ZUNo	1.5	Yes 2□N	Mo
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5	sician: certific irector,	m	exeminer?		Hospital:	1				. 0	AL		h (Check		nca 6 □Oth			
of	Phys this ral di	: To	27. Manner of Deet			1 Inpatien		Time of				irsing Ho			w injury occur		0	
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Si	Te :: e	ca	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could n	ot be	Mana of halis	A4 b ==== 1					110	201 Loon	ion (Ste	eet end Numb	as as Oues	I Pauta Numb	
<u>&gt;</u>	of or Attending effer death.  Director: Af d in by the fu	Certification:	4 Homicide	determi	28e. F	uilding, etc.	y - At home, i <i>(Specify)</i>	rarm, str	et, tector	у, опіса				r Town,		er or mura	noute Mulip	61,
	urs e	ပိ																
	To the Hospital or Atter within 24 hours effer de To the Funeral Directo completely filled in by the	edicai	29a. Certifier (Check only	2 ☐ Madical E	Physician: To xaminer: On ti	ne basis of e	examinetion e	e, death nd/or inv	occurred estigetion	et the t	ime, dete en opinion, dee	d pleca, th occur	end due to red et the	the ce time, da	use(s) end me te end place,	enner es si end due to	eted. the cause(s)	
	the the	Med	one)		end	manner state	ed.		-					-	1.80	1.00	D = 14 = 1	
	S T S	~	29b. Signeture and	title of certifier		MI			29		se number			29	d. Dete signe			
			Cel	yu		111				D.	31997				June 3	0, 19	197	
			30. Name end addr	ess of person v	no completed	cause of dea	ath (Item 23a)	(Type,	Print)					(1.10	572 1	110)		
			Andrew	G. Gor	don, M.	D. 20	03 Med	ical	Par	kwa	y Suit	e 10	00 Anı	napo	lis, M	aryla	nd 214	101
	Sta	te	31. Date filed (Mon			2. Registrer	's Signeture								-	4		
	Registr			UL 01	997	Julia	Devidor	-Man	delle									
			U	- UI		0		-										



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month ROGERS SENIOR 1997 5:50 A.m July 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TAL If Under 1 If Under 24 Hrs. 8. Date of Birth NORTH F

5. Sociel Security Number HOSPI Glen ARUNDEL ARUNDEL 6. Sex 12 M 2 ☐ F Year 9. Birthplece (State or Foreign Country)
NORTH CAROLINA 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Deys Hours 216-05-8101 Yrs. 80 07-12-1916 Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location Od. Inside City Limits 1 ☐ Yes 21 No MARYLAND ANNE ARUNDEL LINTHICUM HEIGHTS 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 911 WANDA ROAD 21090 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3€ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER CAR CARRIER N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) (UNKNOWN) ROGERS MOLLY NEWSOME 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) ROBERT L. ROGERS, JR. 2011 PARK DRIVE, PASADENA, MD. 21122 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) GLEN HAVEN MEMORIAL PARK 7/5/97 GLEN BURNIE, MD. 21. Signature of Moeral 22. Name end Address of Fecility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 Let complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, list only one ceuse on each line. Approximete Intervel Between Onset end Death Immediete Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Last Due to (or es e consequence of): Part II. Other significent conditions polyributing to de 23b. Did tobacco use contribute to the cause of death? an but not resulting ind 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were europsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 Yes 2 No

The law requires that the death certificate be executed P.O. Box 68760. Records, Division of Vital or Attending Physician:

Examiner Examiner attending physician end for use es the buriel-tren Physician/Medicai the the the detach s been signed by t should be detach þ Completed director. Be Certification: To funeral

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

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or items 23a

'natural',

nd Mental Hygiene.

permit. Pages 1 end 2 Depertment of Health e Important: If Item 27 is any injury or other trai once.

Physician /Medical

T is merk

the Medical Examiner must be notified at

Director

Funeral

2

Completed

Be

death with the Maryland

filed within 72 hours efter

Baltimore, Maryland 21215-0020

/Medical

page 2 s this After hours after death.

uneral Director: After his filled in by the fun To the Hospital or within 24 hours aft To the Funeral Discompletely filled in

> State Registrar

edicai

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and manner stated. 29c. License number 29d. Date signed (Month, Dev. Yeer)

60

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

6 Could not be

3 Suicide

29a. Certifier

29b. Signal

31. Date

4 Homicide

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

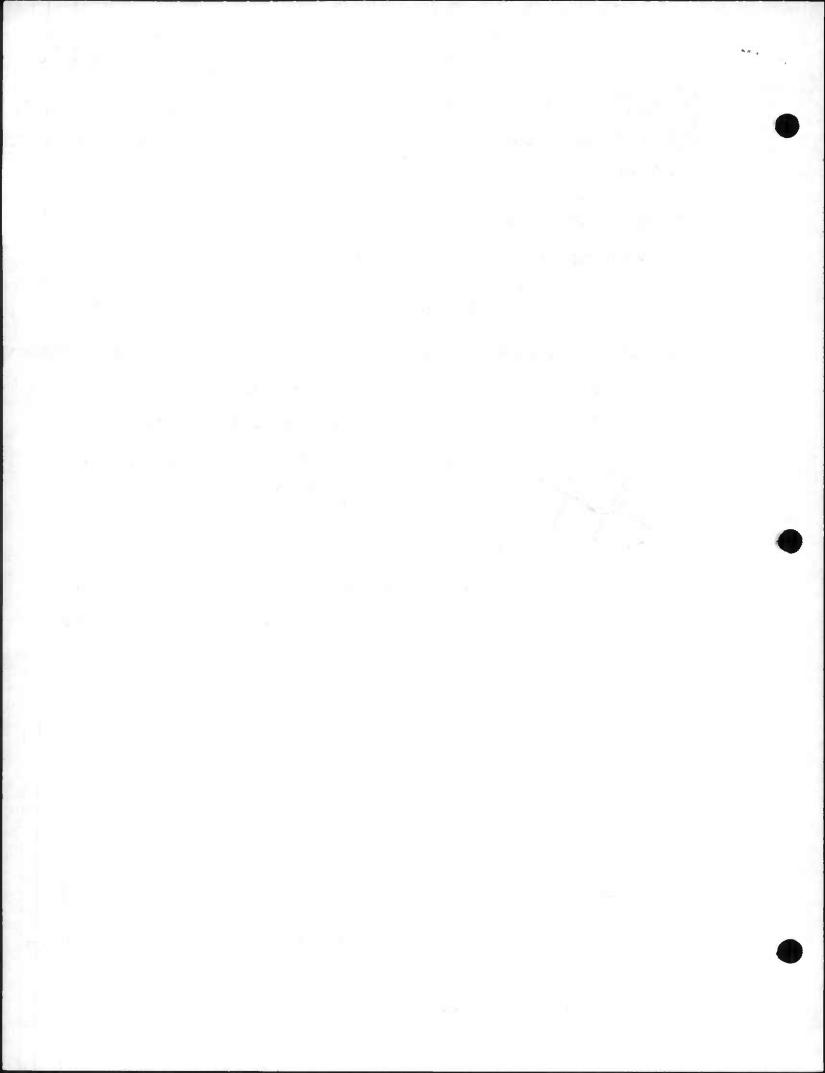
State of Maryland / Department of Health and Mental Hygiene 97 2 13 14

			Certificate of Death		Reg. No.	1 21014
	Dhuaisi		Decedent's Name (First, Middle, Last)	2. Date of Month		3. Time of Death
	Physici /Medic		KATHERINE SCOTT	6		997 7:10 A.M.
7	Examir	ier		wn, or Location of De	ath 4c. Coun	ty of Death
			SALISBURY CENTER: GENESIS ELDERCARE SALIS	BURY	WICO	MICO
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 1 Months Days Hours Usual Residence of Decedent	Min. (Month,	Birth Day, Yeer)	9. Birthplace (State or Foreign Country) West Virginia
	pue #		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary	ō	DE Cueron Delmon			1⊠Yes 2□No
	28a	Director	DE Sussex Delmar  10e. Street and Number 10f. Zip Code		10g Citizen o	f Whet Country?
	with Se or	ā	403 Grove Street 19940		U.S.A	
	ns 2:	Funeral	11, Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Orlg	ain? (Specify Yes or		ace - American Indian,
21215-0020	s 1 and 2 should be filed within 72 hours after death with the Marylend of Heelth and Mentel thygiene. Item 27 is marked other then "natural", or Items 23s or 28s-f show other traumatic event, I'm Medical Examiner must be notified at	by	of the second o	, Puèrto Ricen, etc.)	Spec	ack, White, etc.
2-0	72 ho natur	Completed	15. Decedent's Education 18a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most	of warking	16b. Kind of	Business/Industry
7	ithin en "	ם	(Specify only highest grade completed) (Give kind of work done during most life. DO NOT use retired)  Elementery/Secondary (0-12) College (1-4or 5+)	or working		
	filed within Hygiene. Ither than "	S	4 Teacher		Educa	tion
Maryland	tel H d oth	Be	17. Father's Name (First, Middle, Last)  18. Mother	r's Name (First, Mide	fle, Meiden Sume	me)
yla	should be nd Mentel marked o	2	George W. Matheny, Sr Gyp	sy Bartle	y Mather	ıy
a	2 shc end is m		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street end Number	r or Rural Route Nur	nber, City or Tow	n, State, Zip Code)
	and selth n 27		Ann Gilmore/Daughter 403 Grove Street	Delmar,	DE 199	140
ore	of He		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  20b. Place of Disposition (Neme of cemetery, cremetory or other place)	Date	20c. Location	- City or Town, State
Ē	Peg nent ant: h		4 Donation 5 DOther (Specify) Entombment Blue Ridge Cemetery	7-2-97	Beck1	ey, WV
Baltimore,	permit. Peges 1 and 2 Department of Heelth of Important: If Item 27 is any injury or other tra		21. Signature of Funeral Service Licensee  22. Name end Address of Facility Short Funeral H	lome, Inc.	22	100/0
	_		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as coshock, or heart failure. List only one cause on each line.		ar, DE	19940 Approximate
	Physician		shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death
广	/Medical		Immediate Cause (Final			10.0
	Examiner		disease or condition resulting in death)	aeou		gues,
		Je.	Due to (or as e consequence of):			
	tificete be executed g physician and as the burial-transit	Examiner	Sequentially list conditions.  Due to or as a consequence of:	alon		19.100
Ć	exec in an ial-tr	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury			
68760,	e be rsicia	edical	that initiated events			you.
	tificet ng phy as th	8	resulting in death) Last			
Вох	nding use	N/M	d. arenea			morens
	d for	icia	Darf II. Other algoriticant applitudes applitude to death but as a solitic to the	001 0	MALES	
<u>о</u> .	The law requires that the death centificate be executed ate hes been signed by the attending physician and page 2 should be deteched for use as the burial-transit	Physician/	Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.			ontribute to the cause of deeth?
	thet hed b	by P		'	⊒Yes 2□No	3 Probably 4 Unknown
Records,	n sign			24a. W	as en eutopsy	24b. Were autopsy findings
OS	v require been si should I	Completed		pe	rformed?	available prior to completion of cause of deeth?
Re	s hes	Ĕ				
		e C	OS Was appeared to tradical		☐Yes 2 1 No	1 ☐ Yes 2 ☐ No
⋚	ystcian: The li is certificate he director, page	0	examiner? Hospital:	of Death (Check on		
Division of Vital	Physician: r this certific ral director,	2	1 inpatient 2 EH/Outpatient 3 DOA 4 IZI Nur	rsing Home 5 Re	esidence 8 🗆 O e how injury occu	
o	ding h. After fune	ţ	1 Nature 5 Pending (Month, Dey Year) Injury Work?		o now injury occi	11100
S	Attending or deeth.	ica	3 Suicide 6 Could not be See Blees of lating At home from the officers		(Street and Nun	nber or Rural Route Number,
2	7 5 5 C	Certification:	4 Homicide determined determined building, etc. (Specify)		own, State)	noor or reason reason,
	pital ours eral filled		29a, Certifier 1 Certifying Physician: To the best of my knowledge death occurred at the time date and	t minner and due to the		
	Hos 24 h Fun etely	edicai	29a. Certifier (Check only one)  1. Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner steted.	h occurred et the tim	e, date end place	, and due to the cause(s)
	To the Hospital or within 24 hours efter To the Funeral Dir completely filled in	Z e	29b. Signature and title of certifier 29c. License number		29d. Date sign	ed (Month, Dey, Yeer)
	F S F Ö		10089	19	1/0	Ph-7
	la la	-	20 Name and Address of a supervision of the state of the	7/	0/00	1)'/
	m		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0111		Saliala
	Sta	to		carthw	ay ur	Salisbury, MD
	Registr		JUN 30 1997			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death

	Physicia /Medic Examin	a
1	Funeral Director	
	he Maryland 28a-f show	2000

		м	1. Decedent's Name (First, Middle, L	ast)				2. Date of D	eath	3. Time of Death
	Physic		JAMES	F <	400	CHER		Month	Day	00% 2:15 PM
	/Medi		4a. Facility Name (If not institution, gi		) I HI	CHER	4b. City, Town, or	Location of Dee	th 4c. County	991 0.1011
7	Examir	ier	MODTH ADI	ALD CI	1100	1 Latio	CICIL	110000	- ALAI	E VDIIIVE
Н			5. Social Security Number 6.	Sex 7. Age	(In yrs. lest birt	hday) If Under 1 Year	If Under 24 Hrs	DUKINE	ANIV	EACUNDL
	Funeral		232-50-0662	1⊠M 2□F		Months Days		. (Month, D	ey, Year)	Birthplece (Stete or Foreign Country)
	Director		Usual Residence of Decedent		65			4-5-1	932	WEST VIRGINIA
	land		10a. State 10b. County		10c. City, Towr	or Location				10d. Inside City Limits
	f sh	ō	MARYLAND ANNE A	RUNDEL	SEVERN					1 ☐ Yes 2 No
	28a	Director	10e. Street end Number	KONDEL	SEVERN	10f. Zip Code			10- 04	That County C
	With the second		Too. Street end Humber			Tot. 2ip Code			10g. Citizen of W	vnat Country?
	s 23	Funeral	1311 BERNI RUTH			21144			U.S.A.	
	item item	ů,	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was Decedent of I	an, Mexican, Puer	opecity Yes or Note Rican, etc.)	0- 14. Hace Blac	e - American Indien, k, White, etc.
20	is of	by F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ No if Yes, Give		1□ Yes 2ᢂ No	Specify:		Specify	
21215-0020	be filed within 72 hours efter death with the Maryland tiel Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at			Year or Dates: 1		Daniel de 11			100 100 1 10	WHITE
7	"na	Completed	15. Decedent's E (Specify only highest gi	ede completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of wa	rking	16b. Kind of Bu	siness/Industry
12	with ene.	E C	Elementery/Secondary (0-12)	College (1-4or 5+ 6 YEARS		EACHER			ANINE ADII	NDEL CO. SCHOOL
	Hygi Hygi mt,		17. Father's Name (First, Middle, Las		11	ACHER	18 Mother's Na		, Maiden Sumam	
an	ed in the second	Be		•					, marcon camain	9)
2	should be filed within and Mantel Hyglene.  s marked other than umatic event, the Mantel Mant	ပ	CHESTER STARCHER		401	14.11	HILAH C			
Maryland			19a. Informant's Name/Relationship			Mailing Address (Street				
	is 1 and 2 of Health e Itam 27 is other trai		HILDA V. STARCHER  20a. Method of Disposition	·	131	1 BERNI RUT	TH LANE S			
ō	Pages nent of P int: If Its iry or of		1 Burial 2 Cremation 3	☐Removel from State	cemeter	, cremetory or other ple	ca) j	Date 7-5-1997		City or Town, State
Ë	. Pa men tant:		4 □ Donation 5 □ Other (Special	ify)	CHESAE	EAKE CREMAT	FORY INC.	-3-1337	BELTSVIL	LE, MARYLAND
Baltimore,	parmit. Pages 1 en Dapertment of Heal Important: If Itam 2 any Injury or other once.		21. Signature of Furural Service Lice	nsee		22. Name and Addre		HOME		
щ	20599		W. A	5		SINGLETON 1 SECOND A			MARVIA	ND 21061
	_		23a. Part1. Enter the disease, or con shock, or heart failure. List on	plications that caused to	he death. Do n	ot enter the mode of dyi	ng, such as cardia	c or respiratory	arrest,	Approximate Interval Between
	Physician	1 3	Since Control Control	One cause on each line						Onset and Death
	/Medical		Immediate Cau (Final disease or condition	SE	PTIC	SHO	CK			Hours
	Examiner		resulting in death)			onsequence of):	3 - 1-			10079
		ner				+mIA				DAYS
	cuter	Examiner	Sequentially list conditions.	D		onsequence of):				
Ó	an el	W.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that britished exerts)	CAN	CER	05- 1	UNG			WEEKS
376	nta bu	Ca	that Initiated events resulting in death) Last	Ç		onsequence of):	2010 6			1000 C (-3
Box 68760,	eath certificata be executed ettending physician end for use as the burial-transit	an/Medical	resulting in death/ East							
õ	th ce endii r use	an/		d						
	deat le ett		Part II. Other significant conditions	contributing to death but	not resulting in	the underlying cause gir	ven in Part I.	23b, Did	tobacco use con	tribute to the cause of death?
Ö	The law requires that the der site hes been signed by the e bege 2 should be detached f	Physici				, , ,		12	Yes 2□ No	3 Probably 4 Unknown
ć,	gned be de	by F								
5	v require been sig should t							24a. Wa	en eutopsy	24b. Were autopsy findings available prior to
ပ္ပ	aw re	Set						реп	ormed?	completion of cause of death?
Re	The la	Completed						4.0	Yes 20 No	
Ø		CO	25. Was case referred to medical	T 0 0						1 ☐ Yes 2 ☐ No
5		00	examiner?	Hospital:	2	Oti	26. Place of De			
o	Phys relid	2	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Out		her: 4 \sum Nursing I		how injury occurre	
Division of Vital Records, P.O.	or Attanding I eftar death. Diractor: After I in by the fune	흥	1√Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day		jury Wo	rk?  Yes 2 ⊟ No	755		
S	daal ctor: y the	fica	3 Suicide 6 Could not b	De Diana effetive	v - At home, far	m, street, factory, offica		28f. Location	Street end Numbe	er or Rurel Route Number,
2	or A eftar Dirac	Certification:	4 ☐ Homicide	building, etc.	(Specify)	, 000, 120.0.,, 000		City or To	wn, State)	
	To the Hospital or Attanding Phi within 24 hours effar death. To the Funaral Director: Affar thi completely filled in by the funeral		29a. Certifier 12 Certifying Pl	hyalcian: To the best of	mv knowledge.	death occurred at the til	me, dete and place	a, and due to the	cause(s) and me	nner as stated
	24 P	edical	(Check only 2 Medical Example)	miner: On the basis of e	xamination and	or investigation, in my o	pinion, death occu	rred at the time	date and place, a	and due to the cause(s)
	of thin	Me	29b. Signeture end title of cartifier			29c. Licens	se number		29d. Date signed	(Month, Day, Year)
	->-0		/ varrey	mo		D	4800	2	1.101	= 30 1557
			30 Nama and address of source to	completed serves of 1	oth /ttern Carl C	France District	1 0 0		70101	20 1/1/
			30. Neme and address of person who OLUSEGUN OCIU	UFO WOLA . N	(III (IIII 230) (	nypo, printi) Nuniker 12	acoita.	301	HOSPITA	= 30 1997 TORIVE E, MO
	Cha		21 Date filed (Manth Day Ves-	00 0	's Simeture	101-076 14	DEPTIN	- GLEN	2 SUICIN !	e , mu
	Sta Registr		JUL 03	997	- Deliga	Modello				



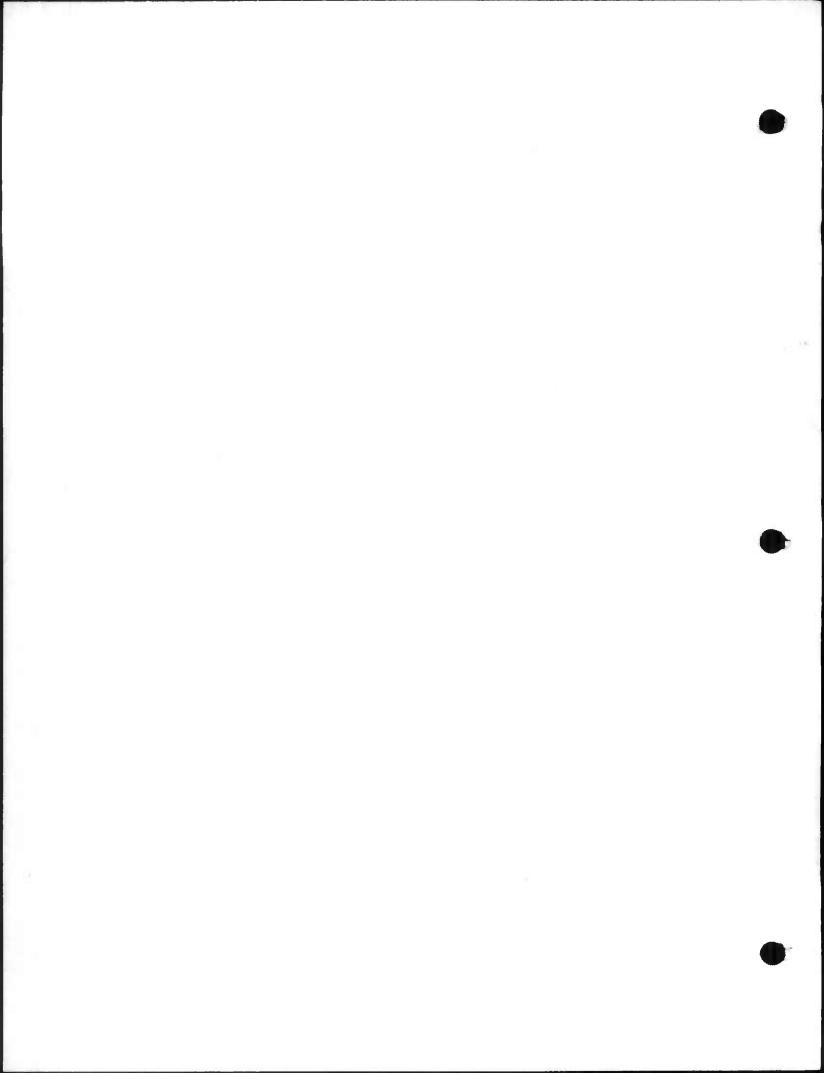
# BALTIMORE, MARYLAND 21215-0020 for death. Page 6 may be retained by the hospital or attending physician. the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
E HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the de-	E FUNERAL DIRECTOR: After this certificate has been signed by the at	d within 72 hours after death with the State Dept. of Health and Ment	RTANT: It item 28 is marked, or item 23 shows any injury
TO THE HOS	TO THE FUN	be filed with	IMPORTAN

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND N	MENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

						OFTIE		DEA			REG. NO			
	1. DECEDENT'S NAME (First	A Middle, Last)			7P	AK	/					30	VEAD	3. TIME OF DEATH
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. Ia	st birthday)	IF UNDER	1 YEAR	IF UNDER	1 24 HRS.		OF BIRTH	00		LACE (State or Foreign
	285-01-0095	5	1 🗌 M 2 🛣 F	98	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month	Day, Year) mber 19	,1898	Country)	
	9a. FACILITY NAME (If not in							OR LOCATION	ON OF DE	ATH		9c. COU	NTY OF DEA	ATH
DIRECTOR	7814 Marrid		3			Ве	the	sda				Mont	tgome	ry County
5	10e. STATE	10b. COUNTY			10c. CIT	Y, TOWN O	R LOCAT	TION					1	IDd. INSIDE CITY
			omery Cou	inty	Bet	hesd	a						,	LIMITS?
FUNERAL	7814 Marrio		2				101	208	E 314			Unit	ed St	
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. AF							? (Specify Yes		14. RACE -	- American Indian.
BY	1 Never Married 2 3 Widowed 4 Dive		IF YES, GIVE V		NO			2 XNO		n, Puerto R	lican, atc.)		Specify:	White
		CEDENT'S EDUC by highest grade		(0	ECEDENT'S Silve kind of v	vork done d			ng	16b.	KIND OF BUS	SINESS/INC	DUSTRY	
COMPLETED	Elementary/Secondary (6	0-12)	College (1-4 or 5	⊦) life	Homen	e retired.)			•		Own Ho	ome		
Sol	17. FATHER'S NAME (First, M										fiddle, Malden	Surname)		
BE	UNOBTAINABI		gunia							CAINA				
2	19a. INFORMANT'S NAME (1 Cynthia Spa		and-Daug								da, Ma			0814
	20a, METHOD OF DISPOSIT 1 N Buriel 2 Crematic 4 Donation 5 Other	on 3 🗌 Remo	ovel from State	20b. PLACE cemetery, cre		her plecel				777	20c. LO		City or Town	
	21. SIGNATURE OF FUNERA		ENSEE #MC	00690	ary C	22. 1	NAME A	ND ADDRES	SS OF FAC	CILITY				120
	Kreve	udb	1 Care	C^0							neral			44109
	23. PART i. Enter the d	iseases, or c		t caused the de	eath. Do n									Approximate
	IMMEDIATE CAUSE (Fir	nai	West Control											interval Between Onset and Death
	disease or condition resulting in death)	<b>→</b> ,	DUE TO	CAR	DIA	-6	11	VF	ARC	TI	ON			ACUTE
,			DUE 10	(OR AS A CONSE	OUENCE OF	-):								
CERTIFICATION	Sequentially list condit if any, leading to imme	diata	DUE TO	(OR AS A CONSE	QUENCE OF	7):								
2	CAUSE (Disease or Inju		DUE TO	(OR AS A CONSE	OUENOE OF									
	that initiated events resulting in death) LAS	T .	, DOE 10	(OR AS A CONSE	OUENCE OF	·);								ĺ
- 11	PART II Other elegifica	ent non-eltion		Acids bile size				250 a to						
EDICAL	PART II. Other significa	in condition	s contributing to	daath but not	resulting i	n the und	cariying	g cause g	given in I	Part i.	24a. WAS AN PERFOR	MED?	A	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE
										-	1 TES 2	NO	0	F DEATH?
Σ	DID TOBACCO U	ISE CONTR	RIBUTE TO CA	USE OF DEA	TH YE	S 🗆 N	10 🗵	LUNC	ERTAIN					U YES 2 □ NO
CIA	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	28. PLAC	CE OF DEAT	H (Check o						_		
PHYSICIAN:	27. MANNER OF DEATH		1 ☐ Inpatient 2 ☐		_	4 🗌 Nurs	ing Hom		eldence	6 🗆 Other				
	1 Natural 5	Pending	(Month, D		28b. TIMI	URY M		RK?	¬ NO	28d. DEŞI	CRIBE HOW I	NJURY OC	CURED	
D BY	3 Suicide 6	Investigation Could not be	28e. PLACE O	F INJURY — At he atc. (Specify)	ome, term, a	treet, facto			_		TION (Street a	nd Number	or Rural Rou	ite Number,
ETE	4 Homicide	determined		ater (epoony)						City o	r Town, State)			
MPL			CIAN: To the best of											
႘	29b. SIGNATURE AND TITLE			Remination and/or	investigatio	n, in my op	pinion, d				end plece, and			ind manner as stated.
8	A CONTRACTOR AND THE		<i>7/1/1</i>	1/11	10	ζ		DA	ENSE NUM	OG		29d. DAT	E SIGNED (A	fonth, Day, Year)
۹ ا	30. NAME AND ADDRESS OF	F PERSON WHO	COMPLETED CAUS	SE OF DEATH (ITE	M 27) (Type,	Print)	$\cap$	00	*	//_		U	11	00 //
	FRANCYS C. 31. DATE FILED (Month, Day,	MAY	11.6 102,	R'S SIGNATURE	DWG	00	KA	_ Q	BE	TH:	5501	1/4	D	20817
	- 1111	n a 190		C. K	. m.	7, 60								
	JUL	A A 192	7	THE PERSON NAMED IN	- March	100	_							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Day 1997 SZILAGYI JUNE 29. 7:30 PM /Medical 4e. Fecility Name (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** NORTH ARUNDEL HOSPITAL ASSN GLEN BURNIE ANNE ARUNDEL | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | 07-18-1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1 □ M 200 F 232-56-9275 Yrs 72 Director VIRGÍNIA Usual Residence of Decedent a or 28a-f show 10e. Stete 10b. County 10c. City, Town or Location 10d, inside City Limits Director 1 ☐ Yes 2XXNo MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 130 DORCHESTER ROAD Pages 1 and 2 should be filed within 72 hours after death w ment of Health and Mental Hygiene.
Int If Hem 27 Is marked other than "natural", or Hema 23a must of the other traumatic event, The Medical Express must ary or other traumatic event, The Medical Express must 21060 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 | Yes 2 | No If Yes, Give Year or Dates: 11. Marital Status Wes Dacadant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puarto Ricen, atc.) 14. Raca - American Indian, Black, Whita, etc. 1 Never Married 2X Married 1 Yes 2X No Specify: Completed by Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 6 N/A HOMEMAKER OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be **JEREMIAH** WILSON MARY MCCREARY 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEVE SANDOR SZILAGYI (HUSBAND) 130 DORCHESTER ROAD, GLEN BURNIE, MD. 21060 of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Depertment of Important: If any Injury or MEADOWRIDGE MEMORIAL PARK 7/2/97 4 ☐ Donetion 5 ☐ Other (Specify) ELKRIDGE, MARYLAND 22. Name end Addrass of Facility SINGLETON FUNERAL HOME, 21. Signeture of Funeral Servica Licensaa 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each time. 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in death) Examiner Examiner the burial-transil Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest end Due to (or es e consequence of). Physician/Medical Due to (or as e consequance of): use es er significent conditions contributing to deeth but not resulting in tha underlying cause given in Pert I. 23b. Did tobacco usa contribute to the causa of death? signed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown þ page 2 should be Be Completed 24a. Was an eutopsy performed? 24b. Were eutopsy findings eveilable prior to eveilable prior to completion of ceuse of deeth? certificate 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes this filled in by the funeral 27. Manner of Death Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Neturel 5 Pending investigation 1 Yes 2 No To the Hospital or Attendl within 24 hours efter death. To the Funeral Director: A 2 Accident 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide The Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier completely (Check only one) 29b. Signature and like of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) # 206 Clan Drini ALELLO PHVII Hospitel

State Registrar

31. Date filed (Month, Day, Year) JUL 01 1997 32. Registrar's Signeture Julia Verida

death with the Maryland

21215-0020

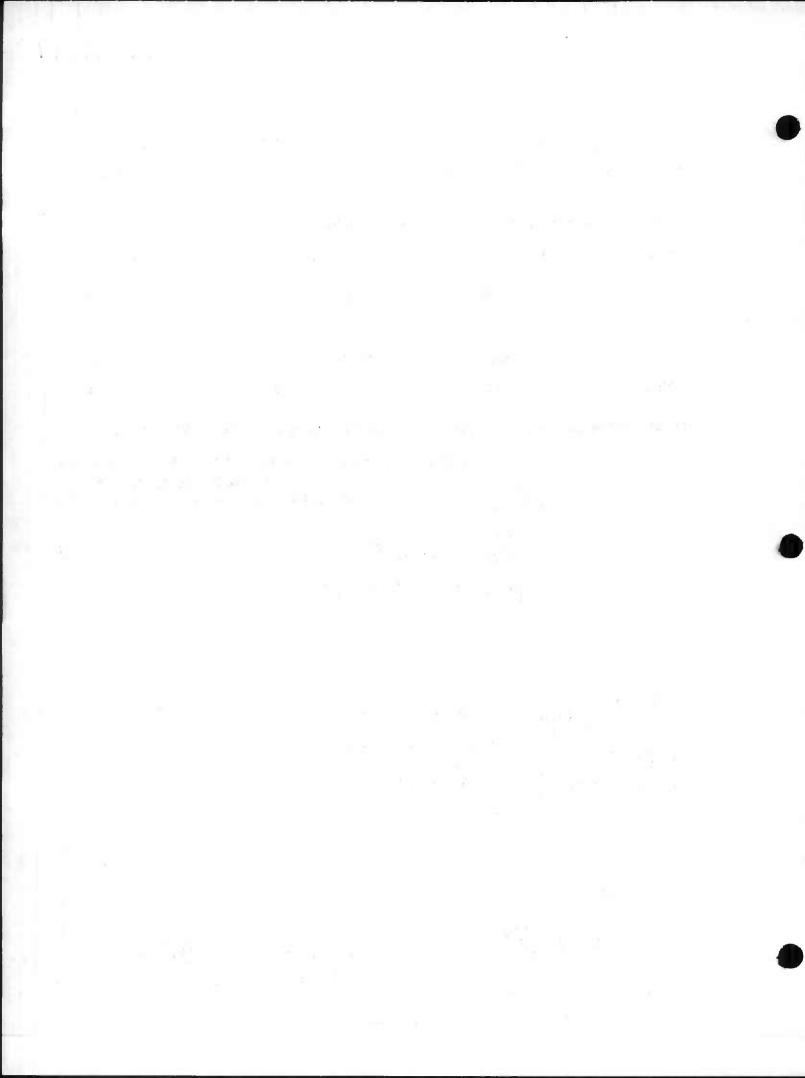
Baltimore, Maryland

The law requires that the death certificate be executed

P.O. Box 68760,

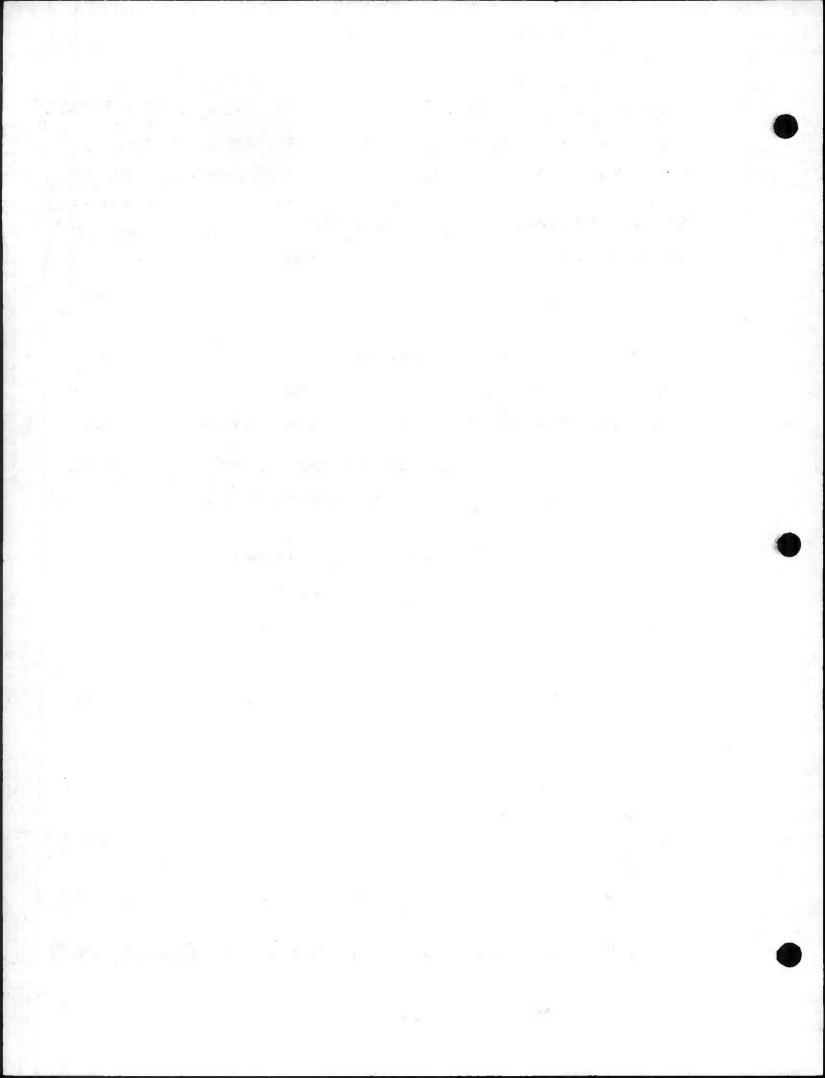
Records,

Division of Vital or Attending Physician:



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 2 | 3 | 8

_					Cer	tificate of	Death	Re	eg. No.		
			1. Decedent's Name (First, Middle, L.	ast)				2. Dete of Deet	h	V. 10	3. Time of Death
	Physici Medie/		Leroy	H Smin	1	IIL		Month	Day	997	2325
T.	Examir		4a. Fecility Neme (If not institution, gi	ve street and number)			4b. City, Town, or Lo	-	4c. County	*	-323
	EAGIIII		University of	Maryland Medi	cal Su	item	Baltin	me	N/		
	Funeral			Sex 7. Age (In yrs. In	10001	If Under 1 Year	7000				ace (State or Foreign
	Director			1 TM 2 F	O Yrs.	Months Deys	Hours Min.	8. Date of Birth (Month, Dey, 06-04-1	Year)	Coun	ry)
Н			Usuel Residenca of Decadent					00-04-1	241	HAKL	DAND
	/lanc		10e. Stete 10b. County	10c. City	, Town or Lo	cation				10	Od. Inside City Limits
	Man	Ö	MARYLAND ANNE	ARUNDEL		GLEN BUR	NTE				1 ☐ Yes 2√2 No
	the 28s	Director	10e. Street end Number	MONDED		10f. Zip Code	MIE	11	0g. Citizen of \	What Count	n/2
	with with					10.12.0000			og. Okizen or i	Wilet Court	ay r
	e 23	era	7561 B & A BOULEY		2 40 14	In December 1	21060	,,,,		S.A.	
	er d	Funeral	11. Marital Status	12. Wes Decedent Ever in U,S Armed Forces?	5. 13. V	Yes, specify Cub	Hispenic Origin? (Spo an, Mexican, Puerto	Rican, etc.)		e - America ck, White, e	
20	n 72 hours efter death with the Maryland "natural", or items 23s or 28s-f show edical Examinet must be notified at	by F	1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorcad	1 ☐ Yes 2 ☑ No If Yes, Give	1	☐ Yes 2X No	Specify:		Specify	. WH	ITE
21215-0020	ural			Yeer or Dates:							
5	within 72 ho iene. than "natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16e. Deced (Give	ent's Usuel Occup kind of work done	petl <i>on</i> during most of workind)	ing	16b. Kind of B	usiness/Ind	ustry
12		m du	Elementary/Secondary (0-12)	College (1-4or 5+)			od)				
			11	N/A	PRES	SMAN	1			INTIN	G
Ē	S E D >	Be	17. Father's Name (First, Middle, Las.	0			18. Mother's Name	(First, Middle, N	Aaiden Suman	ne)	
<del>S</del>		P	LEROY HUME	SMINK, JR	•		VIVIAN			PETE	CRSON
Maryland	end s m		19e. Informent's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Street	t and Number or Rura	al Route Number,	City or Town,	State, Zip	Code)
	Health Health em 27 i		FRANCES MARIE SMI	INK (WIFE)	7561	B & A BO	ULEVARD,	GLEN BUR	NIE, M	D. 21	060
ore	Pages 1 enc ment of Heatt ant: If Item 27 lury or other t		20e. Method of Disposition		eca of Dispos	ition (Name of atory or other pla	ice)	Dete	20c. Location -	City or To	vn, State
Baltimore,	permit. Pages Depertment of Important: If it any injury or once.		1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci	Themoval from Stele			FORY, INC.	1367	DDI mar		
Ħ	orta		21. Signature of Funeral Service Lica	CITE		Name end Addre			BELTSV		
ä	Depermination of the concessio			11/11			· 5.	INGLETON			
			220 Parti Established	C. daffio	102		AVENUE, S			LE, M	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on each line	. Do not ente	r the mode of dyl	ng, such es cardiac d	or respiretory erre	est,		Approximete Intervel Between
	Physician		ALCO PILO NO COMPANO	0						1	Onset end Death
Û	/Medical Examiner		Immediate Cause (Finel disease or condition resulting in deeth)	2/w/s	numa	NE	mbolisa	~		į	
		_	resulting in dee(ii)	Due to (or	es e consequ	uenca oi):				1	
	D #	in		, deep	VIN	throw	bosis			i	
	and tran	Examiner	Sequentially list conditions, if eny, leeding to immediate		es e consequ						
Ő,	e exe		cause. Enter Underlying Ceuse (Diseese or injury							1	
68760,	ertificete be executed Jing physician end se es the buriel-transit	Medical	thet initiated events	Due to (or	as e consequ	enca of):					
	± 00	N N									
Вох	h ce endii r use			d						1	
		Physician	Part II. Other significant conditions of	contributing to death but not resu	Iting In the un	derivina cause aix	ven in Pert I.	23b. Dld to	bacco use co	ntribute to	the cause of death?
0	t the by th tache	'n				,		1□ Ye	11		ably 4 Unknown
S, D		by F						10.1	194110	0_,,00	abiy 4 diminorii
ğ	requires sen sign hould be							24a. Wes er	n eutopsy	24b. We	re eutopsy findings
္ပ		lete						perform	ned?	con	ileble prior to opletion of cause
Record	hes b	Completed							/	of d	leeth?
ल	: The licete he							1 □ Ye	s 2 No	1 🗆	Yes 2 No
Vita	Physician: The this certificete ral director, pag	Be	25. Was case referred to medical exeminer?	Hospital		0.0	26. Place of Deeth	(Check only one	ө)		
ō	Physi this c	မ	1 Yes 2 No	Hospitel: 1 Unpatient 2 E	R/Outpetient	3LI DOA		me 5 🗆 Reside	nce 6 □Oth	er (Specify	)
ב	After t	Certification:	27. Manner of Deeth 1 Maturel 5 ☐ Pending	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ry et rk?	28d. Describe ho	w injury occur	red	
Sio	Attending or death.  actor: After by the fune	cati	2 Accident investigation			M 1 🗆	Yes 2 □ No				
Division	or Attending efter death.  Director: After In by the fune	Ħ	3 ☐ Suicide 6 ☐ Could not be determined		me, farm, stre	et, factory, office	1	28f. Location (Str City or Town	eet and Numb	er or Rural	Route Number,
	tai or rs efte al Dir led in							ŕ			
	To the Hospital or Att within 24 hours efter d To the Funeral Diract completely filled in by	edical	29a. Certifier 1 Certifying Pt	nysician: To the best of my know	ledge, death	occurred et the tir	me, dete end place,	and due to the ce	use(s) end me	nner es ste	eted.
	he H in 24 he Fl plete	Pa Pa	one)	miner: On the basis of examination end manner stated.	on end/or inv	estigation, in my c	opinion, death occurr	ed et the time, da	ite end placa,	ena aue to	tne ceuse(s)
	To the within To the comple	Σ	29b. Signeture and the of continue			29c. Licens	se number	29	d. Date signe	d (Month, E	Day, Year)
			Molsh	MA medical reci	Loint	Po	8653	-	June ?	7	1997
			30. Neme and eddress of person who	completed cause of deeth (Item	23e) (Type F	Print)			-dale	- ')	, , , ,
			Chis A. alia	0 22 5		ene S	2+				
	Sta	te	31. Dete filed (Month, Day, Yeer)	32. Register Bigning	- T	40.00	<i>-</i> 1 <i>-</i>				
	Registr		JUL 01	1997 Julieta	viden-A	andelle					



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

7. Age (In yrs. last birthday)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Death Month JOSEPH C. SMITH JUNE 30 1997 2:55 pm 4a. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth

ANNE ARUNDEL

ANNAPOLIS

/Medical **Examiner Funeral** Director the Maryland Director

**Physician** 

1. Decedent's Neme (First, Middle, Last)

5 Social Security Number

1030 CHESAPEAKE HARBOUR DRIVE

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at filed withIn 72 hours after

10e. Street and Number 10f. Zip Code 1030 CHESAPEAKE HARBOUR DRIVE 21403 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ₺ Yes 2 □ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2XXMarried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) permit. Peges I and 2 should be filed withir Department of Health and Mental Hygiene. Important: if Itam 27 is merked other than any Injury or other traumerin. Elementery/Secondery (0-12) College (1-4or 5+) 12th 2 yrs. SELF EMPLOYED 17. Fether's Neme (First, Middle, Last) Be ABRAHAM R. SMITH ELIZABETH CARR 19e. Informent's Name/Relationship (Type, Print) TERSHEIA SMITH (WIFE) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) ANNAPOLIS MEM. GARDENS 7/3/97 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility lesa 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) Examiner Examiner buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting In death) Lest and Due to (or es e consequenca of) physician a Box 68760. Physician/Medical Due to (or as e consequenca of): esn Division of Vital Records, P.O. the Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. by Completed peen : certificate 1 ☐ Yes I or Attanding Physician: after death. Diractor: After this certific 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 28e. Date of Injury (Month, Dey Yeer) 27. Menner of Deeth Certification: 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 124 hours a To the Hospital 1 Certifying Phyelcien: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) and manner steted. Medical 29a. Certifier (Check only one) within 2 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Narge end eddress of person who completed cause of death (Item 23e) (Type, Print)

32. Registrar's Signeture

If Under 1 Year | If Under 24 Hrs.

Months | Devs | Hours | Min. Birthplace (State or Foreign Country)
 MARYLAND 1X M 2∏ F Yrs. 79 214-05-2821 Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No MARYLAND ANNE ARUNDEL ANNAPOLIS 10g. Citizen of What Country? US 14. Race - American Indian, Black, White, etc. Specify: BLACK 16b. Kind of Business/Industry SMITH CHARTER BUS SERVICE 18. Mother's Name (First, Middle, Malden Surneme) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 1030 CHESAPEAKE HARBOUR DRIVE ANNAPOLIS, MD. 21403 20c. Location - City or Town, Stete ANNAPOLIS, MD. WM. REESE & SONS MORTUARY, P.A. 821 WEST ST, ANNAPOLIS, MD, 21401 Approximete Intervel Between Onset end Deeth Raus 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Was en eutopsy 2. No 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Thesidenca 6 Other (Specify) 28d. Describe how Injury occurred

2003

Registrar

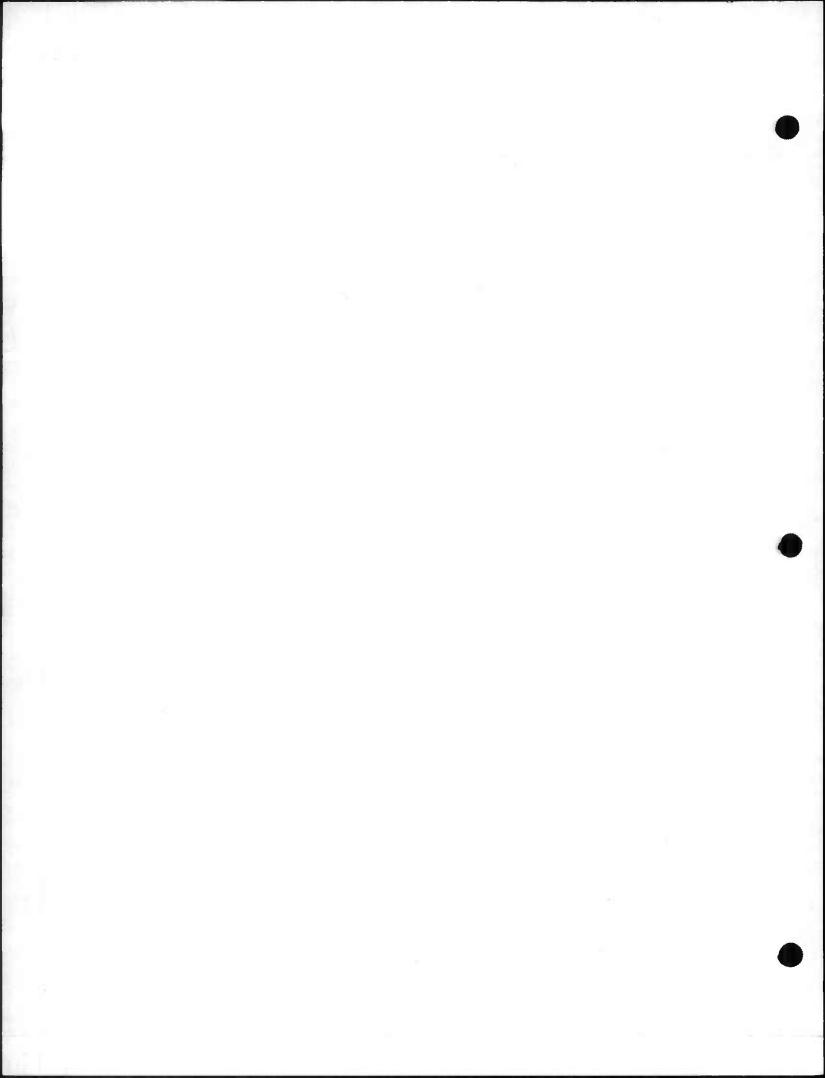
31. Dete filed (Month, Dey, Year)

JUL 02 1997

DHMH 16 Rev 6/95

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 2 1 3 2 0

						Certific	ate of l	Death		Reg. No.				
	Physici	ian	Decedent's Neme (First, Middle     Reta M. Smelse						2. Date of De			Time of Death		
	/Medi Examir		4a. Fecility Neme (If not institution,		r)		4	b. City, Town, o	or Location of Deet			14 G.III.		
			Golden Crest F		airfield		1	stminst			Carroll			
	Funeral Director		5. Social Security Number  220–16–1773  Usuel Residence of Decedent	6. Sex 7. A 1 ☐ M 2 1 F	ge (In yrs. last birl	Mon	ths Deys	If Under 24 H Hours Mi		th ey, Yeer) 8, 1900	9. Birthplace Country)	(State or Foreign		
	how		10a. Stete 10b. County		10c. City, Towr							Inside City Limits		
	he Ma	Director	MD Carroll Westminster							1 ☐ Yes 2				
	ath with ti	ral Dir	10e. Street and Number 811 Fairfield	Ave.		101	. Zip Code	211	157	10g. Citizen of	Whet Country? United			
21215-0020	be filed within 72 hours after death with the Maryland tal Hyglena. d other than "natural", or flems 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Maritel Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Yes 2 V If Yes, Give Year or Dates:	No		ecedent of Hi specify Cube es 21/2 No		(Specify Yes or No erto Rican, etc.)	Specify	e - American I ck, White, etc.	ndien, Nhite		
15-0	natur	eted	15. Decedent' (Specify only highest	15. Decedent's Education (Specify only highest grade completed)  [Give kind of work done during most of work life. Do NOT use retired)						16b. Kind of B	usiness/Industr	ry		
2121	within ena. than	Completed	Elementery/Secondary (0-12)	College (1-4or	5+)	Tife. DO NO Homema	_	)	Own Ho		ome			
pu	2 should be filed within end Mental Hygiena. is marked other than sumatic event, the M	BeC	17. Fether's Neme (First, Middle, L		18. Mother's N	ame (First, Middle	, Meiden Sumen	10)						
ylaı	ould b Ments arked	70	George C. Morningstar							Bohn				
, Maryland			19a. Informant's Neme/Reletionsh Hazel Bixler,							ovan Pike, Westminster, MD 21158				
Baltimore,	permit. Pages 1 and 2 Department of Health e Important: If item 27 is any injury or other tra once.		20e. Method of Disposition  1 ☑ Burial 2 ☐ Cremetion  4 ☐ Donation 5 ☐ Other (Sp			y, cremetory adow E	or other plec sranch	Cemeter			City or Town, inster,			
Bal	Depart Import any in		21. Signature of Funeral Service L	into - Sweits	, , ,				Home & C Rd., Wes		r, MD 2	21157		
			23a. Part1. Enter the diseese, or coshock, or heart failure. List of			not enter the	mode of dying	g, such es card	iac or respiretory e	rrest,	Inte	proximete ervel Between		
	Physician /Medical Examiner		Immediete Ceuse (Finel diseese or condition resulting in death)	e. DEMS	Due to (or es e o	コ <u></u> にいしょん	26551V	6			YEA	set end Death		
	led sit	Examiner		<b>b</b>										
Ć,	ficata be axecuted physician end is the burial-trensit	Exar	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	tions, Due to (or es e consequence of): adiete na										
68760,	ata be nysicia he bui	Medical	Ceuse (Diseese or Injury thet Initiated events resulting in deeth) Last	C	Due to (or es e c	onsequence	of):							
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	daath he atte	Physician/	Pert II. Other eignificent condition	e contributing to death I	but not resulting in	the underlyi	ng ceuse give	en in Pert I.	23b. Did	tobacco use co	ntribute to the	cause of deeth?		
P.0	hat the da od by the a detached	Phy	ARTERIOSCLE	4	400-	7			1□	Yes 20 No	3 Probabl	y 4 🗆 Unknown		
ds,	uires that signed t	d by	DISTERIORCE	COTIC F	TERM	D/ 1 C	V41 12		24e Wee	An autoney	24h Were e	autonsy findings		
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Vital			25. Was cese referred to medical	HYPERTE	NEION					Yes 2. □1\vio	1 □ Ye	es 2 No		
>	Physician: this certific rel director,	o Be	exeminer?	Hospital:	ient 2 ☐ ER/Out	tpetient 3	DOA Othe	NP:	Home 5 Resi		er (Snecity)			
n of	D FE O	on: T	27. Menner of Deeth 1 □Naturel 5 □ Pending	28a. Dete of Inj (Month, Da	ury 28b. T	<u> </u>	28c. Injury Work	et		how injury occur				
Division	Attending Ph ar death. ector: Aftar th by the funerel	cat	2 Accident investigation in Suicide 6 Could no	t be		М		Yes 2□No						
DIV	al or Attendir s aftar daath. si Director: Af ed in by the fu	Certification:	4 ☐ Homicide determin	ed 286. Piece of in	ijury - At home, far tc. <i>(Specify)</i>	m, street, fe	ctory, office		City or To	Street end Numb vn, State)	er or Hurel Ho	ute Number,		
	Hospit 4 hour Funere tely fills	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Phyeician: To the best caminer: On the basis of and menner si	of examination end	death occur Vor investiga	red et the tim tion, in my op	e, date end ple pinion, deeth oc	ce, end due to the curred et the time,	ceuse(s) end me date end plece,	enner es steted end due to the	i. cause(s)		
	To the within 2 To the compla	M	29b. Signature and title of certifier	~ 1			29c. License	number		29d. Date signe	d (Month, Dey,	Yeer)		
			Versent	Dre.	or In	ms	Do	1663		6/21	197			
			30. Neme end eddress of person w		deeth (Item 231)	Type, Print)	8 12n	1663 rewor	20	· · ·				
	Sta	te	31. Dete filed (Month, Day, Year)	FLOCE 3E. Regist	ar's Signature	0.00	WEST	MINS	Ter, n	0 21	157			
	Sta		11111071	007	Butter Ka	dall.								



Amendoot#5 10b, 100, Please Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedeni's Name (First, Middle, Last) 2. Data of Deeth 3. Time of Death Month **Physician** Vaar GERTRUDE JUNE 28, SMILEY JUNE 1997 /Medical 7:10 PM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner CUMBERLAND If Undar 24 Hrs. 8. [ CUMBERLAND NURSING HOME ALLEGANY 5. Sociel Security Number If Undar 1 Year 6. Sex 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Dey, Yeer) **Funeral**  Birthplaca (Stata or Foreign Country) Months Days Hours Min. 1□ M 2√ F 79 Yrs. Director 214-05-7956 June 4,1918 MARYLAND the Maryland to or 28a-f show 10b. County 10e Stete 10c. City, Town or Location Allegany 10d. Inside City Limits Director 1 Vas 2 No ALLELGANY CUMBERLAND 10e. Street end Number Somer Uille 10f. Zip Code 10g. Citizen of Whai Country? 220 SOMMERVILLE AVENUE, APT. 411 21502 23a U.S.A. Examiner rount death Funeral itams ? 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: 13. Was Dacedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indien, Bleck, White, etc. 11. Marital Stetus filed within 72 hours aftar 1 Never Married 2 ☐ Married 21215-0020 "natural", or 1 ☐ Yes 2X No Specify: WHITE þ Specify: 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ith and Mental Hygiena. 27 ie marked other than "r r traumatic evant, the Med Elementery/Secondary (0-12) College (1-4or 5+) ASSISTANT SHOE REPAIR 2 Baltimore, Maryland 17. Fathar's Name (First, Middla, Last) Peges 1 and 2 should be fill ment of Haalth and Mental Hillant: If item 27 te marked oth 18. Mother's Name (First, Middla, Maiden Surnema) Be GOTLEIB FORSTER PEARL PEEBLES 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Numbar, City or Town, Stete, Zip Code) GEORGE FRED SMILEY/SON 12403 GRAMLICH ROAD, LAVALE, MD 21502 or other 20b. Plece of Disposition (Neme of cematary, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) HILLCREST BURIAL PARK 7/2/97 CUMBERLAND, MD 21. Signatura of Funeral Sapvice Licensee 22. Name end Addrass of Fecility GEORGE-UPCHURCH FUNERAL HOME, P.A. 23e. Pert1. Enter the disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical CORONARY ARTERY DISEASE 10 Years Examiner Due to (or as a consequence of) Examiner The law requires that the death cartificate be executed burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury lhet initiated events resulting in deeth) Lest Dua to (or es e consequence of): Records, P.O. Box 68760. physician Physician/Medical tha Due to (or es a consequence of): or usa as Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Chronic Obstructive Pulmonary Disease yd ber 1K Yes 2 No 3 Probably 4 Unknown þ page 2 should be 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? peen certificata hes 1 Yas 2 No 1 ☐ Yas 2 ☐ No of Vital al or Attending Physician: T s eftar death. I Director: After this certificat diractor, Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) exeminar? 9 Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatieni 2 ☐ ER/Outpetient 3 ☐ DOA funeral 27. Menner of Deeth Certification: 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Division 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident tha To the Hospital or Attel within 24 hours efter der To the Funaral Director complately filled in by th 6 Could not be determined 3 Suicida Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, sireet, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) to certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es steted.

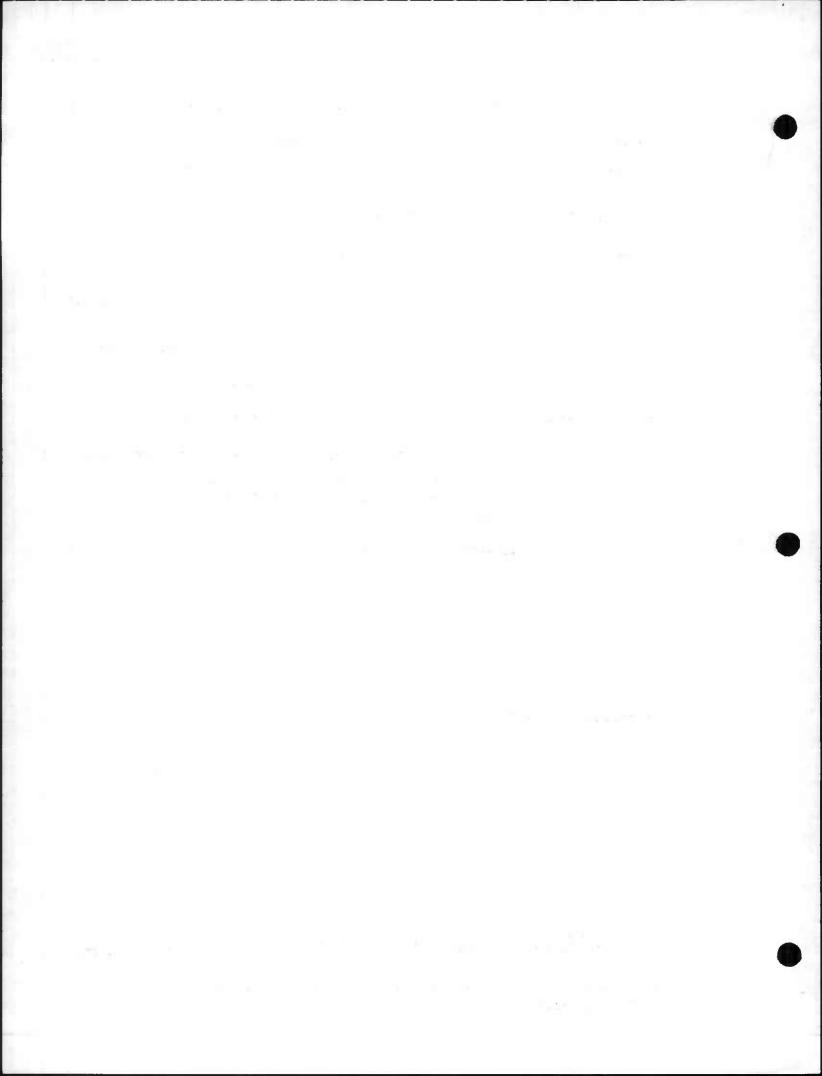
2 ☐ Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end manner stated. Medical 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D33280 June 29,1997 nono 30. Name end eddrass of person who completed cause of daath (Item 23e) (Type, Print) Gupta, M.D.-625 Kent Ave., Cumberland, MD 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 2 1 3 2 2

					Cer	titicate of	Death		Reg. No.			
н	Dharais		Decedent's Name (First, Middle, Las					2. Date of Do		Vana	3. Tim	e of Death
П	Physic /Medi			ELEANOR Vi	rginia	SN	YDER	June	25, 199	Year 7	8:	10 am
	Exami		4a. Facility Nama (If not institution, give	street and numbar)			4b. City, Town, or	1				
			Memorial Hospit	:al			Cumber	land	A11	egany		
	Funeral		Social Security Number     6. Si		last birthday)	If Undar 1 Yaar Months Days		8. Data of Bi	rth 19 Year 1910	9. Birthple	ace (Sta	te or Foreign
	Director		214-05-4535	□м 2🗅 ғ 🛮 86	Yrs.	Months Days	Hours Will	Aug.	1970	CMD	ry)	
	p.		Usual Residence of Decedent									
	show	_	10a. State 10b. County  MD Allegany		ty, Town or Loc Cumber					10		e City Limits
	Ba-f	cto			Cuilber	Taria.					1131	res 2□No
	or 2	Director	10e. Street and Number 12811 Old Church	Tana		10f. Zip Code			10g. Citizan of V		ry?	
	23a	Ta.	12811 Old Church	Lane		2150	2		US	A		
	r de	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	l,S. 13. W	as Decedent of I	Hispanic Origin? (Span, Mexican, Puer	Specify Yas or Norto Rican, etc.)	o- 14. Rac	e - Amarica k, White, e		٦,
20	or it	Y	1 Never Marriad 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva		□Yas 2□No			Specify		hite	
00	urai'	d by	3 Widowed 4 Divorced	Year or Dates:								
Maryland 21215-0020	filed within 72 hours after death with the Marylend Hyglene. Wher than "natural", or Itama 23a or 28a-f show ent, the Maxical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	16a. Decede	ent's Usual Occu and of work done	pation during most of wo d)	orking	16b. Kind of Bu	ısiness/Indi	ustry	
7	within	E G	Elementary/Secondary (0-12)	College (1-4or 5+)	Retire		a)		Crysta	al Lau	ındr	У
7	Hygic ther int,	ပိ	17. Father's Name (First, Middle, Last)				18 Mothar's Na	me (Firet Middle	a, <i>Maidan Surn</i> am	e)		
an	d be intal	Be C	Jacob L. Snyder	•			Ada (E		i, maidan Sumam	6)		
2	d 2 should be filed within head Mental Hygiene. T is marked other than "traumatic event, it a Men	2	19a. Informant's Name/Relationship (7	ima Cristi	406 144-116-				- V AV T	O		
Ma	ges 1 end 2 should be filed within 72 hours after death with the Maryler to f Health end Mental Hyglene. If Item 27 is marked other than "natural", or itams 23s or 28s-f show or other traumatic event, the Mydical Examinar must be notified at		Judy Snyder-daug		12809	Old Ch	and Number or Rurch Lane	e Cumber	land MD	21502	2	
ė,	1 en Heal em 2		20a. Method of Disposition	20b F	Placa of Dispos	ition /Nama of		Date	20c. Location -	City or Tow	un State	
timore,	Pages nent of h int: If ite		1 ☐ Burial 2 ☐ Cramation 3 ☐	Removal from State	illcrest	Memori	al Park	06/27	Cumber			
	it. P.		4 Donation 5 Other (Specify 21. Signature Funeral Service Liceni						0011001			
Ba	permit. Pages 1 end 2 Department of Health e important: If item 27 is any Injury or other trai		21. Signature Puneral Service Licen	1- 11	/ 22.	Scarpe	isi Funer and MD 2	al Home				
	17		yares +	1 Carple	1.							
			23a. Party Enter the dismase, or comp show, or heart failure. List only of	acations that carried the doat one cause on each line.	h. De not ante	r the mode of dyi	ng, such as cardia	c or respiratory	arrest,		Approxi Intervel	Between
	Physician /Medicai		Immediate Cause (Final	CEREBROVASCU	IT AD AC	TDENT				1	DAY	nd Deeth
	Examiner		Immadiata Cause (Final disease or condition resulting in death)	a	LAK AC	CIDENI					DILL	
		P.	,	Due to (d	or es a consequ	ience of):				1		
	nsit	Examiner		b						-		
_6	certificate be axecuted Iding physician end use es the burial-transit	Exa	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying	Due to (c	or as a consequ	ience of):				i		
760	sicia sicia		Ceuse (Disease or injury that initiated avents	C	(2011 Jug 110)							
68760,	ificat g phy es th	edical	resulting in death) Last	Dua to (o	r as a consequ	ance or):						
×		M/n		d								
n	death e etter d for u	lcla	Part II. Other significant conditions co	stributing to death but not rec	ulting in the un	doduina anusa ai	von in Dort i	22h Did	tobacco use cor	authura an	the eas	on of death?
Ö	The law requires thet the death ita has been signed by the etter paga 2 should be detached for	Physicia			anny in the and	deliying cause gi	voil iii Fait i.		Yes 20 No			Unknown
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ğ	v require been sig should b								s an autopsy	24b. Wer	re autop	sy findings
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Ĭ	The law cata has paga 2	E						10	Yes 2 No		Yes :	n D No
Vital Records,		Be C	25. Was case referred to medical				26 Place of Do	ath (Check only	Mr. Tille		105	20140
>	Physician: r this certifica arel director, g	0	examiner?	Hospitel: Impatient 2 🗆	ER/Outpatient	3□ DOA Ott	hae		idence 6 Oth	or /Specific	1	
0	Physical dereil	Ë	27. Manner of Deeth	28a. Date of Injury	28b. Time of	28c. Inju		1	how injury occurr		/	
0	offing f th. : After e funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yeer)	Injury		rk? ]Yes 2 ☐ No					
Division of	ii or Attending Physician: efter death. Diractor: After this certific d in by the funerel director,	He	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of Injury - At no		et, factory, office			(Street and Numb	er or Rural	Route N	lumber,
בֿ	s efter	Certification:	4 Difficition	building, etc. (Specif	у)			City or To	wn, State)			
	hour hour unera		29a. Certifier 1 Certifying Phy	alcian: To the best of my kno	wledge, death	occurred at the ti	me, date and place	e, end due to the	ceuse(s) end ma	nner as sta	ated.	
	To the Hospital or A within 24 hours efter To the Funeral Dirac completaly filled in b	edical	(Check only 2 ☐ Medical Examone)	iner: On the basis of examina and mannar stated.	tion and/or inve	estigation, in my	opinion, death occi	urred at tha time,	, date and place,	and due to	the caus	se(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signal	(Month, D	ay, Yea	r)
	6		> Willia	n tun	1 Mb	D 2	5406		June	2:	7,	1997
	m10		30. Neme and address of person who c	ompleted cause of death (Iten	n 23a) (Type, P	rint)					-	
	1400		Dr. William Lamm			-Cumberl	and, MD	21502				
	Sta	te	31. Date filed thouth Day Year 100				•					

Registrar



B.K.S JESSICA A. STEVENS

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Dep

artment of Health and Mental H	ygiene	9	1	2	I	3	2	
rtificate of Dooth								

						Certificate	of Deati	ר	Re	g. No.					
			1. Decedent's Name (First, Middle, La	ist)	N 1				te of Death			3. Time of Death	1		
	Physic								onth NE		Year 997	4:34 P	M		
/Medica Examine			4e. Facility Name (If not institution, giv	re street and number)			4b. City, 1	own, or Location		4c. County of					
Ĺ			FRANKLIN STRE		ROSSING		BERLAND		ALLEC						
	Funeral Director		5. Sociel Security Number 6. S 216-94-2007  Usual Residence of Decedent	7. Age 1 M 2 ∑ F	23		ays Hours	Min. (M	te of Birth onth, Day, y 6,			ece (State or Forei iry) Caroline			
	/lend		10a. State 10b. County		10c. City, Town	or Location					10	d. Inside City Limit	ts		
	se Man	Director	Maryland Allega	any	Cun	berland						1☐XYes 2☐N	10		
	th with the 23a or 2								10	g. Citizen of W US		Country?			
020	d within 72 hours efter deeth with the Maryland jiens. r than "natural", or liens 23s or 28s-f show the Medical Examiner must be notified at	by Funeral	3 ☐ Widowed 4 ☒ Divorced If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuben, Mexican, Puerto Rican, etc)     1 □ Yes					- America k, White, e Whi	etc.			
Maryland 21215-0020	"natural",	Completed	15. Decedent's En (Specify only highest gra		16ø.	Decedent's Usual C (Give kind of work of	lone durina mo	est of working	11	6b. Kind of Bus	siness/Ind	ustry			
12	within 72 ena. than "nat	di	Elamantary/Secondary (0-12)	Collega (1-4or 5	+)	life. DO NOT usa	,			Own H	Iome				
d 2	등 독특	ပိ	17. Father's Name (First, Middle, Lest	)		Homemak		ner's Name (First	Middle M						
/lan	a la p >	To Be	George R. Baker					orah (Wh		asoon oomanic	7				
an	d 2 should th end Mer 7 Is marke traumatic	_	19a. Informant's Name/Relationship (	Type, Print)	19b.	Mailing Address (S	treet and Num	ber or Rural Rout	e Number,	City or Town, 5	State, Zip	Code)			
			George R. Baker			22 Avonda		, Cumber	land,	MD 21	1502				
ore	ges 1 en it of Heal If Item 2 or other		20a. Mathod of Disposition  1  ■ Burial 2 □ Cremation 3 □	Demoval from State	20b. Place of cemeter	Disposition (Name y, crematory or other	of r plece)	Dat	e 2	Oc. Location - (	City or Tov	vn, State			
Ĕ	Pag ment: It ant: It		4 Donation 5 Other (Specif		Hillere	est Memor	ial Par	k 7/3	/97 (	umberla	and,	MD			
Baltimore,	permit. Pages 1 er Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Furnitural Service Licer	1500		22. Name and A	ddress of Fac	ity Kight	Funer	al Home	3				
	_		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications thet caused	ne death. Do n	I					וב עוני	Approximate			
	Physician /Medical Examiner	ler	Immediate Ceuse (Final disease or condition rasulting in death)	a. <u> </u>	out to (orlas a c	le Dyi	wills				1	Intarval Batween Onset and Death			
ox 68760,	leath certificate be axecutad ettending physician end I for use es the bunal-transit	VMedical Examiner	Medicai	Medicai	Sequentially list conditions, if any, leading to immadiata causa. Entar Undartying Cause (Disease or Injury that initiated events resulting in death) Last	C	Oue to (or as a c	onsequence of):							
Bo	death le etter ed for u	sicial	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	the underlying caus	e given in Par	1. 2	3b. Did tob	acco use con	tribute to	the cause of deet	th?		
P.0	that the led by th detach	y Physician/					given in the				3 Prob				
of Vital Records,	ew requi	Completed by						2	4a. Was an perform		con	re autopsy findings ilable prior to npletion of cause leath?	5		
E	0 - 0	Corr							1 Ves	2 🗆 No	埤	Yes 2 No			
/ita	sician: The cartificate rector, pag	Be (	25. Was case referred to medical examiner?				26. Pla	ce of Death (Che	ck only one	)					
7	Physician: this cartific ral director,	L <sub>o</sub>	1. Yas 2□ No	Hospital: 1   Inpatier		patient 3 DOA	<del></del>	lursing Home 5	Residen	ce XXOthe	r (Specify	RAILRO	AD		
	ng P		27. Manner of Death 1 □ Natural 5 □ Panding	28a. Date of Injur (Month, Day		ime of 28c.	Injury at Work?	1 6	escribe hov	v Injury occurre	od O	TRACK	S		
sio	Attending or death. Sector: After by the fune	cati	2 Accidant investigation 2 Suicide 6 Could not b	- VSU 9 7	- 04	SCHR		No Ser	ojec	- // -	- ca	ry man	1		
Division	l or Attending after death. Director: After d in by tha fune	Certification:	4 Homicide datamined	28a. Place of Inju building, atc.	ry - At home, far . (Spacify)	m, street, factory, o	ffice		cation (Stre ity or Town,		K/L	Route Number,			
	oral C	- 1	00-0-4	-		Elltrac	us	Cush	nos	Cumbe	1000	Mary an	-9		
	Hosp 24 ho Fune Fune	edical	29a. Certifiar 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of niner: On the basis of	examination and	death occurred at t Vor Investigation, in	ha tima, data a my opinion, da	ind place, and du ath occurred at t	a to t <del>hé</del> cau ha tima, dat	usa(s) and man la and place, a	nnar as sta nd dua to	ated. / the cause(s)			
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Med	29b. Signature and title of certifier	and manner star	ed.	29c 1	cense number		20	d. Date signed	(Month I	Day Year)			
	) 5.₹₹.8		and things contino	11-6			.C.M.I	7	23	JULY		1997			
	5		" Medare	U. The	1 my		. C . M . I			OOLI	<b>+</b> ,				
	nes		30. Name and eddress of person who												
	, ,,,,,,			Miking		enn Str	eet, I	Baltimo	re,	Maryla	and	21201			
	Sta Registr		31. Date filed (Month, Day, Year)	97 Stand	r's Signature	vilalle									

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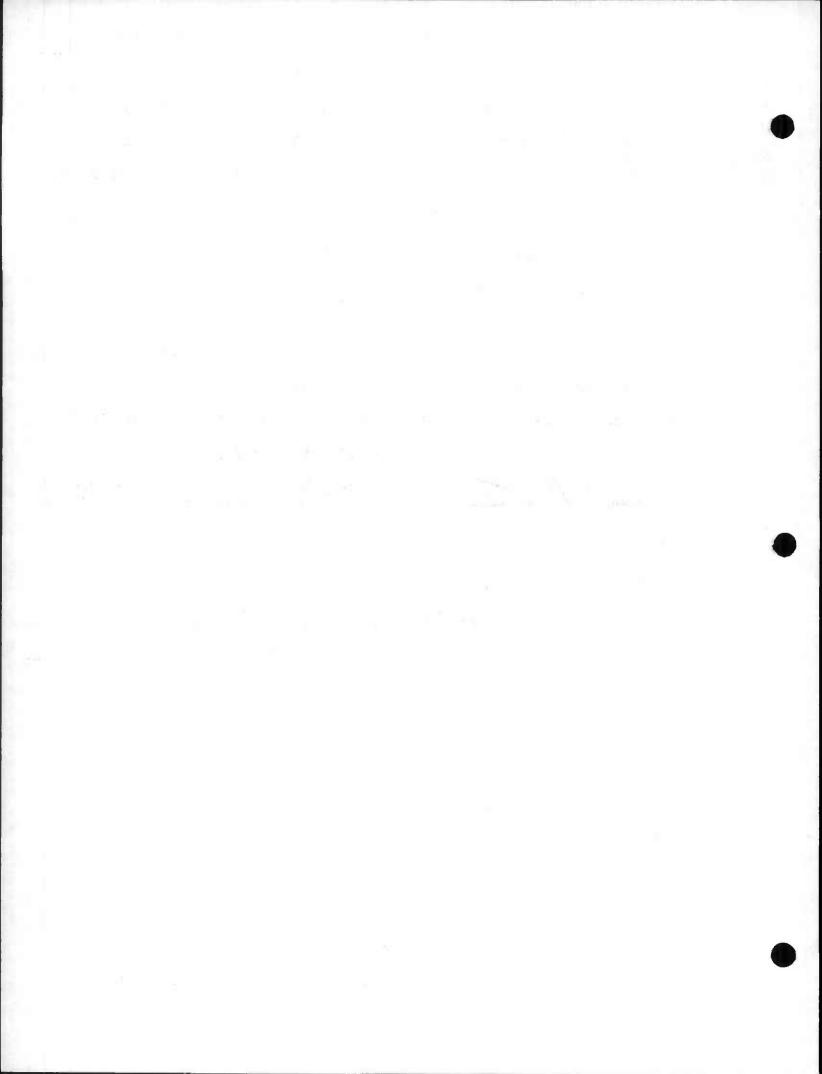
					Ce	ertificate of	Death		Reg. No.			
ŗ	Discorto		1. Decedent's Name (First, Middle, Last)					2. Data of Da _Month		Yaar	3. Tima ol Death	
	Physici /Medi		NELLIE MAE	SWARTZ				JÜLY 1	, 1997	Taai	0015	
	Examir		4a. Facility Nama ( <i>If not institution, gi</i> va s Sacred Heart				4b. City, Town, or L Cumber			of Deeth Lgany		
	Funeral Director		5. Social Security Number  164-28-2618  Usual Rasidance of Dacedant	7. Age (In 87	yrs. lest birthda Yrs.	y) If Under 1 Yaar Months Deys	If Undar 24 Hrs. Hours Min.	8. Date of Bir Month, Pa 4-6-10	th y, Year)	9. Birthpl Count Hyndm	ece (Steta or Foraign try) an, Pa.	
	/land		10a. Stata 10b. County	10c	. City, Town or	Location				10	Od. Insida City Limits	
	a Man	ctor	Pa. Bedford	1	Bedfor	ıd					1 X Yas 2 □ No	
	with the	i Director	10e. Street and Number 124 W. Pitt St.			10f. Zip Code 15522	)		10g. Citizan of V USA	Vhat Count	ry?	
020	i within 72 hours efter death with the Meryland iene. then "netural", or items 23s or 28s-f show the Medical Exercines must be notified at	by Funeral		12. Was Decedent Ever Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaer or Detes:	in U,S. 13		Hispanic Origin? (Sp an, Maxican, Puarto	ecify Yes or No Rican, atc.)		a - America k, Whita, a		
2-0	72 hou		15. Decedant's Educ (Specify only highast grada	cation	18a. Dec	edent's Usuel Occu	pation	ina	16b. Kind of Bu	siness/Ind	ss/Industry	
Maryland 21215-0020	within ene. than "	Completed	Elementery/Secondery (0-12)	College (1-4or 5+)		DO NOT usa retire	during most of work d)			taru	tary education	
pu	0 = 0 >	BeC	17. Fethar's Nema (First, Middle, Last)				18. Mothar's Nam		Maiden Sumem	e)		
yla	should be nd Mantal marked o	2	Jasper				Viola El		-			
	od 2 :		19e. Informant's Name/Ralationship (Type Mrs. Frances Cla				end Number or Aur US, Pa. 1		er, City or Town,	Stata, Zip	Coda)	
Baltimore,	as 1 an of Haai I Itam 2 r other		20a. Mathod of Disposition	20	b. Plece of Disp cematary, cr	position (Nama of amatory or other ple	ce)	Data	20c. Location -	City or Tox	wn, Stata	
ti m	ment lant: If		1 ☑ Burial 2 ☐ Crametion 3 ☐ Re 4 ☐ Donation 5 ☐ Othar (Specify)	amoval from Stata		. Lutherar		-3-97	RD #1 Buf	balo N	lills, Pa.	
Bal	permit. Pagas 1 ar Dapertment of Haa Important: If Itam 3 any Injury or other once.		21. Signatura of Funeral Service Cicense	e. D. O. O.		22. Nama and Address imothy A. B	erkebile Fur na St., Bedf	peral Home	Inc.			
	- 1		23a. Part1. Entar tha diseasa, or complic shock, or haart tailure. List only on	cations that caused the caused on aach lina.	death. Do not a	ntar tha moda of dyl	ng, such as cardlec	or respiretory e	rrest,		Approximata Intarval Batween	
	Physician /Medical Examiner			Ischemi						i	6 months	
	P =	ner		Marren	to (or as e cons	equance or):	tona			-	3 YEMMU	
	tificate be executed ig physician and as tha burial-trensit	Examiner	Sequentially list conditions, if any, laading to immediate cause. Enter Undarlying								5 / 6 / 6	
60,	be ex		Cause (Disaasa or Injury									
68760,	ficate p phys as tha	Medical	that initiated events rasulting in daath) Lest	Due t	o (or as a conse	equance of):						
Box	eath cart		d.									
	e deat	Physician/	Part II. Other significant conditions cont			underlying causa gi	ven in Part I.	23b. Dld	tobacco use cor	ntribute to	the cause of death?	
P.0	ed by detach	/ Ph	atuil film	lletin				10	Yes 2□ No	3 ☐ Prob	ably 4 Unknown	
of Vital Records,	iew requires that the death cartificate be executed es been signed by the ettanding physician and 1.2 should be detached for usa as the burial-trensit	Completed by	Sidetis h	ellity	_			24a. Was	an autopsy	con	ra autopsy findings ilable prior to appletion of causa	
Re	Tha lev ata hes paga 2	ошо						10	Yas 2 No		leath? ] Yes 2□ No	
ita		Be C	25. Was casa rafarred to medical				26. Place of Deat				100 2010	
> >	Physician: r this cartific tral director,	To	axaminar? 1 ☐ Yes 2 No	ospital: 1 Inpatiant	2 ☐ ER/Outpati	ent 3 DOA	her: 4 Nursing Ho	ma 5 □ Rasi	danca 6 Oth	ar (Specify	)	
	fta Ing		27. Mannar of Death 1 PNeturel 5 □ Panding 2 □ Accident invastigation	28a. Data of Injury (Month, Day Yea	28b. Tima Injury	Wo	nyat nk?  Yas 2 □ No	28d. Dascribe	how Injury occur	red		
Division	l or Atte after da Directo d in by tf	Certification:	3 Suicida 6 Could not be determined 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 28f. Location (Street and Number or Rural Route Num City or Town, Stata)							Route Number,		
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this complataly filled in by the funaral of	edical C	29a. Certifiar (Check only one)	icien: To the best of my er: On the basis of exan and manner stated.	knowledga, daa nination and/or i	ath occurred at the ti invastigation, in my	ma, data and place, opinion, daeth occur	and dua to tha red et the tima,	causa(s) and ma data and place, a	nnar as sta and due to	ated. tha causa(s)	
	To th To th comp	ž	29b. Signatura and title of cartilier	11		29c. Licen:			29d. Dete signe		Jey, Year)	
	12		1 my C. On	Mun		1 -	023894-	E	7/11	97		
	MI		30. Name end eddrass of person who con Gregg C. Donaldson ND,									
	Sta	te	31. Date filed (Month) Day, Year 100			t, 14. 15545						

Registrar

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					(	Certific	cate of		F	leg. No.	
	Dhoole		1. Decedent's Nama (First, Middla, La	st)	7				2. Data of Dea Month	th Dey Yaar	3. Time of Death
	Physici /Medi		Jerry	Lynn			Smith	n	June	28, 199	7 11:45AM
	Examir		4a. Facility Nama (If not institution, giv	e straat and number)				b. City, Town, or Lo	ocation of Death		
			Memorial Ho	spital @ E	astor	1		Easton		Talbo	t
	Funeral		5. Social Security Number 6. S	Sex 7. Aga (In	yrs. last birth	day) If U	Jndar 1 Yaar	If Undar 24 Hrs.	8. Data of Birth (Month, Day		thplace (State or Foreign ountry)
	Director		239-50-3886	M 2□ F	63 Y	rs.	nths Days	Hours Min.	Jan. 20	5,1934Nor	th Carolin
	pur *		Usual Rasidence of Decedant  10a. Stete 10b. County	100	. City, Town	or Location	1				10d. Inside City Limits
	sho	'n		albot	East		,				1 XYes 2 No
	the N	Director	10e. Street and Number				4 7in Code			0-02	
	Nith of	급				10	f. Zip Coda			log. Citizan of What Co	ountry?
	s 23	rai	6202 Waterloo				2160			U.S.A.	
	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ★ Married	12. Was Dacedant Evar Armed Forces? 1 ☐ Yas 2 ☑ No	in U,S.	13. Was D	Decedant of H , specify Cuba	ispanic Origin? (Sp in, Mexican, Puarto	ecify Yes or No- Rican, atc.)	14. Race - Ame Black, Whi	
21215-0020	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f show he Mexical Examiner must be notified at	by F	3 ☐ Widowed 4 ☐ Divorced	If Yas, Give		1 🗆 Y	as 2½ No	Specify:		Specify: Wh	nite
9	natural',		15. Decedant's E	ducation	16a. I	Decedant's	Usual Occup	ation		16b. Kind of Business	/Industry
215	s 1 end 2 should be filed within 72 hd Heelth end Mental Hygiene. tem 27 is merked other then "natur other traumatic event, the Mexical	Completed	(Specify only highast gra Elementery/Secondary (0-12)	ade completed)  College (1-4or 5+)	(	'Give kind o Iifa. DO No	of work dona OT usa ratired	ation during most of work t)	ing		
21	d with piene. r than	EO	12	4	Pl	ant	manaq	er	r	Medical E	guipment
	il Hygi other	Be C	17. Fathar's Nama (First, Middla, Last	)				18. Mothar's Name			
Maryland	should be filed withind Mental Hygiene. marked other than immite event, train	TOE	Colie Wilson Si	mith				Eula Ma	ae Wili	liams	
ary	2 should end Men is marke aumatic		19a. Informant's Name/Ralationship (	Type, Print)	19b.	Mailing Add	dress (Street	and Number or Run	al Route Numbe	r, City or Town, Stata,	Zip Coda)
Σ	1 end 2 : Heelth er am 27 ls other trau		Jean Burns Sm	ith	62	02 W	aterl	oo Drive	e, East	ton, MD 2	1601
Je,	of Heelth Itam 27 other tr		20a. Mathod of Disposition	20	Ob. Place of I	Disposition	(Nama of	ea)	Data	20c. Location - City or	Town, Stete
Baltimore	0 0 0 0		1 ☐ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spacif	Ramoval from Stata C	hesap	eake	Crem	ation 6,	/30/97	Stevensvi	lle, MD
=======================================	permit. Peg Depertment Important: I any injury o		21. Signature of Funeral Service Joy		enter		na and Addra	ss of Facility_			
ä	Dep Jung any		11 9611	. All		rer	TOWS,	неттеп		Newnam	
		-	23a Part Enter the disease or com	Minations that caused the						n St. Eas	Approximete
	Dhamisia		23a. Part1. Entar tha disease, or com shock, or heart failura. List only	ona cause on each line.	- DOTA	st armar tria	mood or dyn	g, scori as cardiae	or respiretory en	631,	Intarval Batween Onset and Death
	Physician / /Medical		Immediata Causa (Final	11 1	1	0.					
	Examiner		disaasa or condition rasulting in death)	a. Rysker	v au	eune					1
		ē		I/a a . L	to (or as a co	onsequance	e or):	/			
	uted d ansit	Examiner	Comments the first and distance	b. Iregissue	1 run	onsequence	o'oth	~		,	[
Ć,	The law requires that the death certificate be assouted ste hes been signed by the ettending physician end page 2 should be detached for use es the burlei-transit	Exa	Sequantially list conditions, if any, leading to immediate cause. Enter Undartying Ceusa (Disaasa or Injury that initiated avants rasulting in daath) Last	Moto	ha!		24 - 0 4	la Pr	4 Hes	Inder.	3 week
68760,	sicia e bu	cai	Ceusa (Disaasa or Injury that initiated avants	c. Dua:	to (or as a co	nsequance	of):	PO 466	a roge	200	7000
	g phy es th	Physician/Medical	rasulting in daath) Last	Cuncu	2422	d	Pi	11 1/00	es hu	101	7.m.
Box	andin use	N/		d	va vue	1	Jug	me of the	or nu	W.	0.745
	death e ette	sicla	Pert II. Other significant conditions of	contributing to death but no	t rasulting in	tha underly	ving cause giv	an in Part I.	23b. Did to	obacco use contribut	e to the cause of death?
P.0	t the by th	hys	<b>3</b>						1004		Probably 4 Unknown
	es thet the death cer igned by the ettendin be detached for use	ру Р									
Records,	v require been sig should b								24a. Was a		Wera autopsy findings available prior to
ပ္ပ	w requ	Completed							parfor	niau:	complation of cause of death?
R	sician: The law certificete hes b lirector, page 2 s	E							1□ Y	as 212No	1 □ Yas 2 □ No
Vital		BeC	25. Was casa referred to medical					26. Place of Deet			12.10
<u>&gt;</u>	Physician: The I this certificete he ral director, page	To B	axaminer? 1 ☐ Yas 2 ☑ No	Hospital:	2 ☐ ER/Out	natient 3	DOA Oth	or:		ance 6 □Othar (Spe	acify)
o	5 5 6		27. Menner of Deeth	28e. Date of Injury (Month, Day Yea		ma of	28c. Injur Wor			ow Injury occurred	
<u>o</u>	ath. r: Aft	atio	1 ☐Naturel 5 ☐ Panding 2 ☐ Accidant investigatio		ir) in	jury M		Yas 2□No			
Division	Atte or dei by th	ific	3 ☐ Suicida 6 ☐ Could not b 4 ☐ Homicida datarmined	286. Placa of injury -		n, straat, fa	actory, offica		28f. Location (S City or Tow	treat and Number or F	Rural Routa Number,
	s effe	Certification:	4   Nomicida	building, etc. (Sp	эөспу)				City of 10w	n, State)	
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral	edicai (	(Check only 2 Medical Exar	nysician: To the best of my ninar: On the basis of exar	knowledge,	daeth occu	irred at tha tin	na, data and place, pinion, daath occur	and dua to tha c	ausa(s) and mannar a lata and placa, and du	s stated. a to tha cause(s)
	the hin 2 the the l	Med	one)	end mannar statad.		- 0-(0)					
	5 N N	_	29b. Signatura and titla of certifiar	11.1 11	) 1	VA	29c. Licans		1	29d. Date signed (Mon	m, Day, Year)
			▶ Welliam	DWood	+ '	・レ	126	18715		0/20/	7/
			30. Nama and address of parson who							MD 01501	
			Dr. William H.			Idle	wild A	Ave., Ea	ston,	MD 21601	
	Sta		31. Data filed (Month, Day, Year) $JUL - 1 10$	32. Registrar's S	Signatura	n .					
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State of Maryland / Department of Health and Mental Hygiene Amended item # 5. WCHD 6/24/97 ir Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day **Physician** 9:02 A.M George T. Smith 1997 June 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 2835 N. Salisbury Boulevard Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Yeer) **Funeral** <del>214</del> <del>225</del>-36-5002 1**X** M 2□ F Months Davs Hours Min Yrs. Director 57 Sept. 8, 1939 Maryland Usual Residence of Decedent death with the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD Wicomico Salisbury 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? or Items 23e or 2835 N. Salisbury Boulevard U.S.A. 21801 11 Marital Status 12. Wes Decedent Ever in U,S. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates neturei', White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Architect Architecture 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Peges 1 and 2 should be fit Department of Health and Mental H Important: If Item 27 Is marked ott any Injury or other traumatic ever Be Peges 1 and 2 should be nent of Health and Mental David Smith 2 Florence Stemple Smith 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 2835 N. Salisbury Blvd. Janice Smith/Wife Salisbury, MD 21801 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Cambridge Crematory Cambridge, Maryland 21. Signature of Funeral Service Licensee 22. Neme end Address of Facility Short Funeral Home, Inc. 13 E. Grove ST. Delmar, DE Shad-Hanniga 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner sician and burial-transit requires thet the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequence of) nding physician ause es the burial Box 68760, Physician/Medical Due to (or as e consequence of) P.O. I Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of death? signed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Records. by page 2 should 24b. Were eutopsy findings evailable prior to Completed 24e. Wes en eutopsy completion of cause of deeth? The law 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA Certification: To 1 Yes this funeral 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide To the Hospital of within 24 hours a To the Funerel D completely filled in Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) end menner es steted.

Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. Medicai 29a, Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6 anny 30. Name end eddress of person who completed ceuse of dean (Item 23a) (Type, Print) 124 118 De EASTERN 400 SHORE DALISBURY. 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State plin Davidson Rardall JUN 2 4 1997 Registrar

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State of Maryland / Department of Health and Mental Hygiene

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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth JUNE: 29, 1997 ESTELLA VOISEY 8:15 PM 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death CUMBERLAND NURSING HOME CUMBERLAND ALLEGANY If Under 1 Year 7. Age (In yrs. last birthday) if Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) Deys Hours Months 1 □ M 2 🗗 F 85 Yrs July 10,1911 MARYLAND 10c. City. Town or Location 10d. Inside City Limits ALLEGANY **CUMBERLAND** 1X Yes 2 No 10f. Zin Code 10g. Citizen of Whet Country? **#1 BALTIMORE STREET** 21502 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2X No Specify: Specify: WHITE 3 Widowed 4 □ Divorced Yeer or Dates 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry WV DEPARTMENT OF Elementary/Secondary (0-12) College (1-4or 5+) NATURAL RESOURCES SECRETARY 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surneme) ROLAND RICHARD GILBERT LULU MAE SPRIGGS 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) THOMAS G. VOISEY / SON 307 McGILL DRIVE, CUMBERLAND, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Burial 2 □ Cremation 3 □ Removel from State 7/2/97 4 ☐ Donetion 5 ☐ Other (Specify) OLIVET CEMETERY PARKERSBURG, WV 21. Signature of Funerel Service License 22. Name end Address of Facility GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502 23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, Approximete Interval Between Onset end Deeth iation Due to (or es e consequence of) CVA Due to (or es e consequence of): Due to (or es a consequence of)

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permit. Pages 1 and 2 should be filed within 72 hours effer a Department of Health and Mentel Hygiene. Important: if them 27 is marked other than "naturel", or iten any injury or other traumatic event, the Medical Exemptions.

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5. Social Security Number

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Usual Residence of Decedent

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Immediate Cause (Finel disease or condition resulting in death)

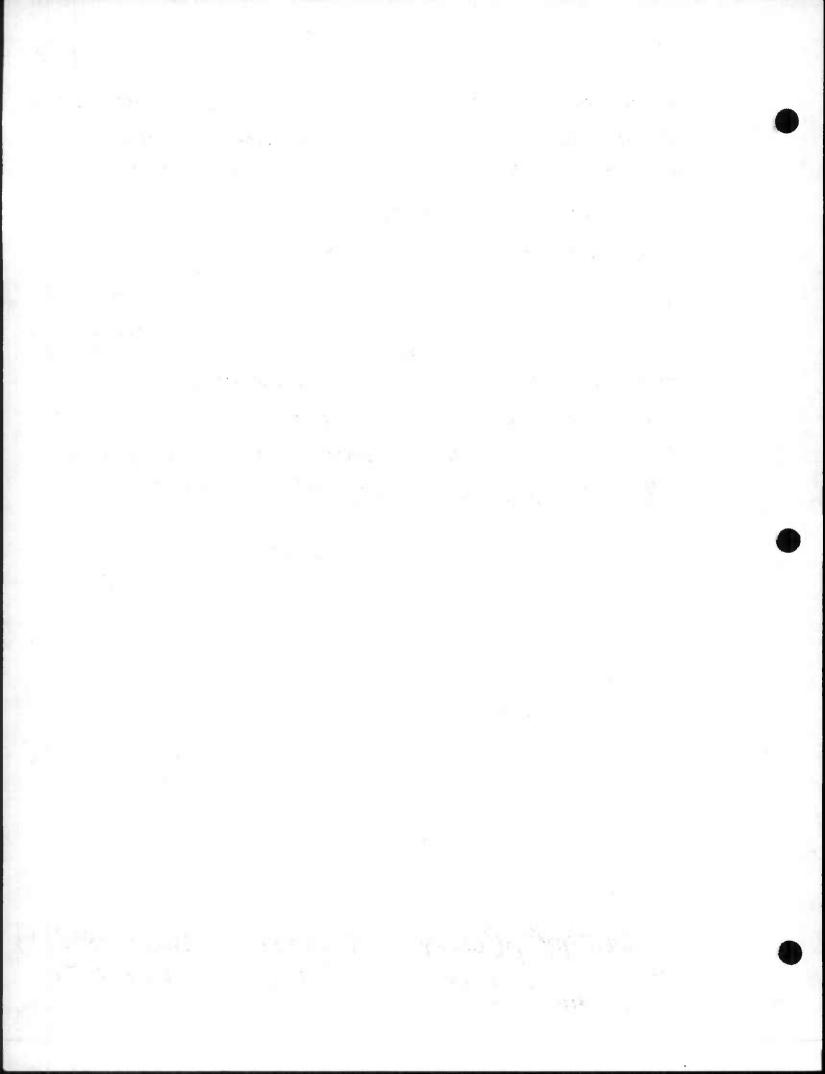
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32. Registrar's Signature

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State Registrar



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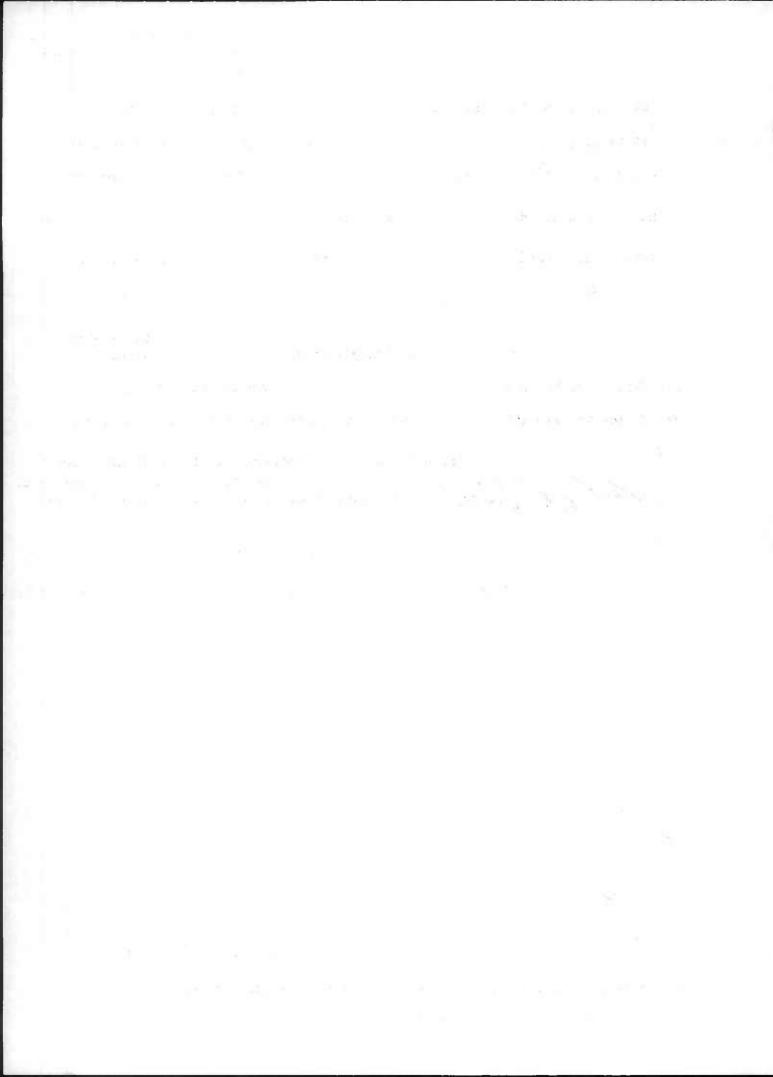
Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Death 3. Tima of Daath **Physician** Month Yaar William John Van Wie, Jr. June 28 1997 12PM /Medical 4a. Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1147 Hampton Road Annapolis Anne Arundel 5. Social Security Number If Undar 1 Year If Under 24 Hrs. 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** XXM 2□ F Months Days Hours Yrs. Director 055-26-2979 64 Jan 12 1933 New York Usual Rasidanca of Decedant Pages 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mantal Hygiena and if them 27 is marked other than "natural; or hems 23s or 28s-f show any or other traumatic event, the Medical Evaluers mant be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Annapolis 1 ☐ Yas XIX No Director 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 1147 Hampton Road 21401 United States Funeral 12. Was Decadent Evar in U,S. Armad Forcas? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien, Black, White, atc. 11. Marital Status IXXYas 2□ No1952 If Yes, Giva 1 Navar Merried Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2XXXVo Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced 1977 Year or Datas: Be Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast grade complated) United States Elementery/Secondary (0-12) College (1-4or 5+) Military/Retired Government 17. Father's Nema (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Surname) Dr. William J. Van Wie Mary Isabelle McHugh 2 19a. Informant's Nama/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Fay Janice Van Wie (Wife) 1147 Hampton Road Annapolis, Maryland 21401 20b. Placa of Disposition (Name of camatary, cramatory or other pleca) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 ☐ Cramation 3 ☐ Ramoval from Stata permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Othar (Specify) Arlington National Cemetery July 10, 1997 Arlington, VA 22. Name end Addrass of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Fi 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Pert1. Entar the disaesa, or complications that causad the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one ceuse on each line. Onset end Daath **Physician** /Medical Immediata Causa (Final META STADE CARCINUMA

Dua to (or as a consequence of): disaase or condition rasulting in daath) **Examiner** Examiner LUNG CALCINOMA To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Yeneral Director: After this certificate has been signed by the attending physician and completaly filled in by the ituneral director, page 2 should be deteched for use as the burnal-transit Sequentially list conditions, if eny, laading to immadiata ceusa. Enter Underlying Causa (Disaasa or Injury that initiated avents rasulting in daath) Last Box 68760. Physician/Medical Dua to (or es e consequance of) P.O. I director, page 2 should be datached Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ Completed 24b. Wara autopsy findings aveileble prior to 24a. Was an autopsy completion of causa of daeth? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Wes casa referred to medical axaminar? Be 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatiant Other: 4 Nursing Homa 5 Assidance 6 Other (Specify) ٩ 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Menner of Death

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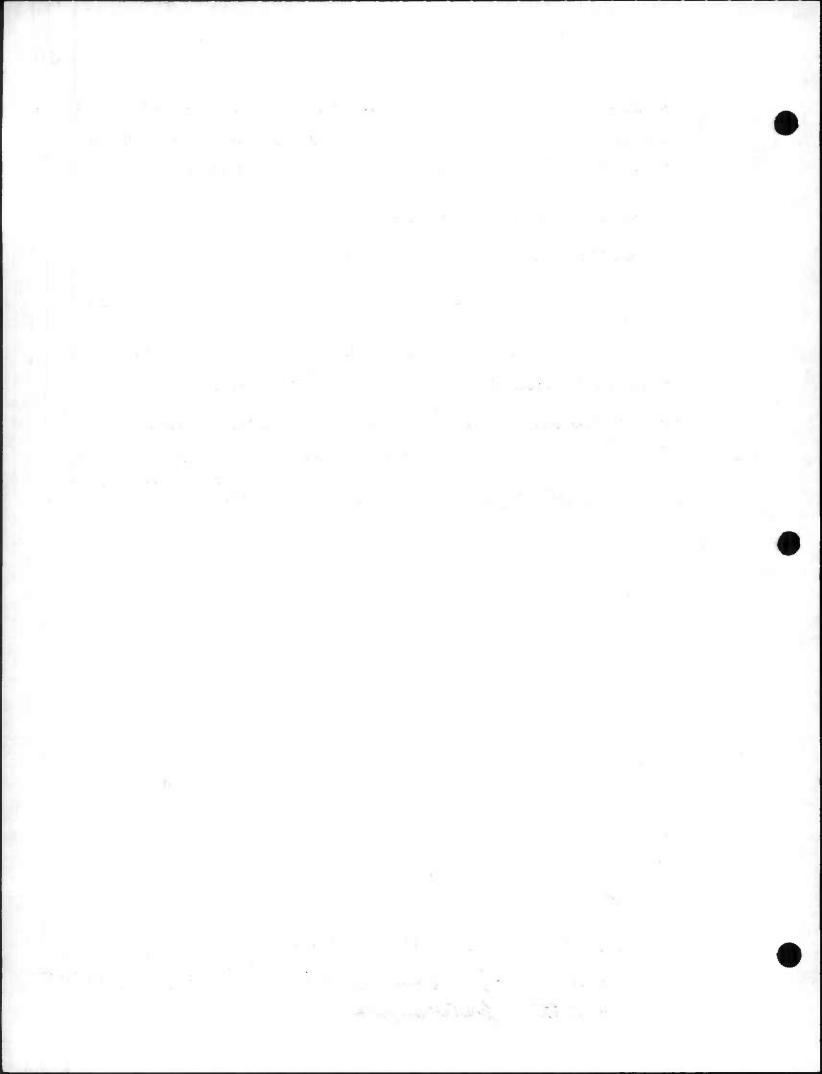
2 □ Accident 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Dascribe how injury occurred 5 Panding invastigation 1 Yas 2 No 6 Could not be datarminad 3 ☐ Suicida 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Spacify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 4 Homicida Cartifying Physician: To the best of my knowledge, death occurred at the time, data end placa, and due to the cause(s) and manner as steted.

2 Medicat Exeminar: On the besis of axeminetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to tha causa(s) and mannar stated. 29a. Cartifiar Medical (Check only one) 29b. Signature and titla of certified 29c. Licansa number 29d. Data signed (Month, Dey, Year) June 30, 1997 30. Name and eddrass of person who completed cause of death (Itam 23a) (Type, Print) David Jaller, M.D.706 Gidding Avenue Suite 1A Annapolis, Maryland 21401 31. Dete filed (Month, Day, Year) 32. Registrar's Signatura while Davidson 0 1 1997 Registrar



State of Maryland / Department of Health and Mental Hygiene 97 2 1 3 3 0

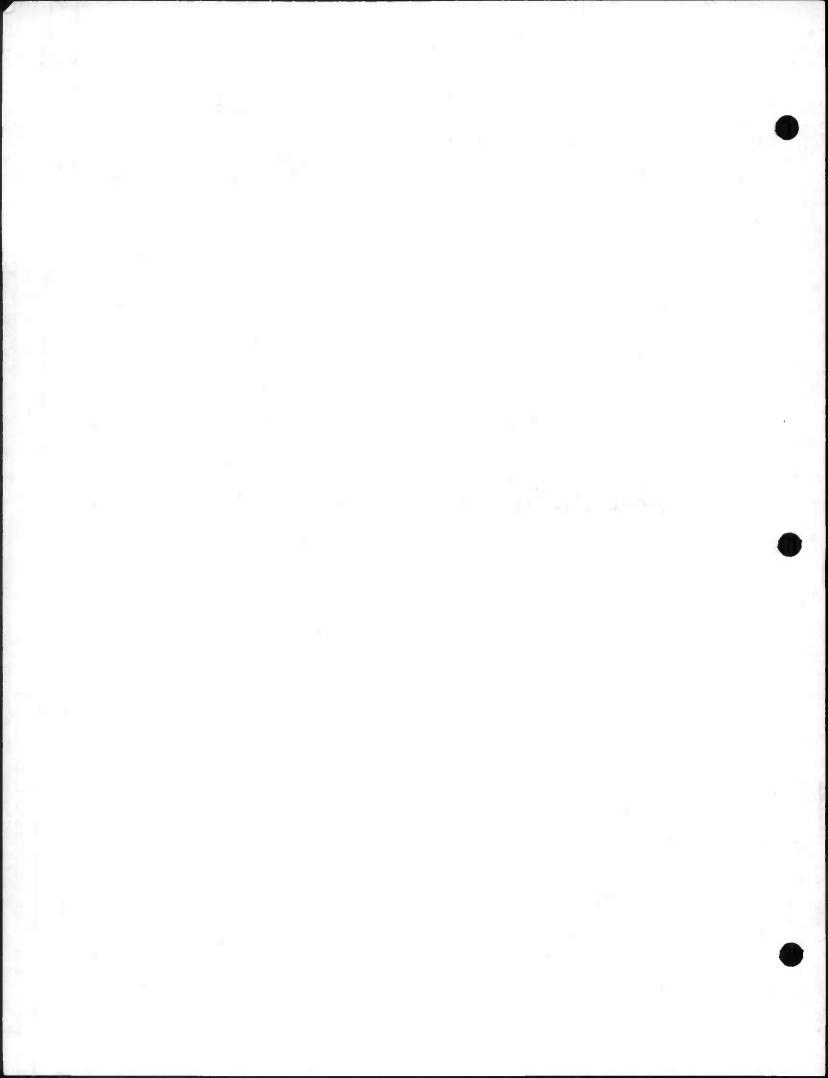
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ot	Physician: The lainthis certificate heseral director, page 2	J.	1 Yes 2 No			☐ ER/Outpatie	-	UA			me 5 Resider			(y)	
Division of Vital	Afte fun	tion	1 Neturel 5 □ Pendin		of Injury th, Day Year)	28b. Time Injury	of M	28c. Inju Wo	ryet′ rk?  Yes 2 □		28d. Describe ho	w injury occu	rred		
181	eat or:	fica	3 Sulcide 6 Could r	ot be	of Injury - At	home, farm, s			1163 2		28f. Location (Str.	eet and Num	ber or Rura	al Route t	Vum <i>ber</i> .
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	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	edical (	29a. Certifier (Check only 2 Medical I	Phyeician: To the examiner: On the b	best of my kr	nowledge, dea	th occurred	et the ti	me, date en	d plece,	end due to the ce	use(s) end m	enner es s	teted.	sp(s)
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State of Maryland / Department of Health and Mental Hygiene 97 2 1 3 3

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Ph	ysicia	an.	Decedent's Neme (First, Middle,	•	. 1				2. Dete of Month	Death		Yeer		of Deeth
	Medic		WRIGHT,	MARY	N				dune		23	1997	16:	37
Ex	amin	er	4e. Fecility Name (If not institution,				C1- 1		n, or Location of De	ath 4	lc. County	of Death		
			UNIVERSITY of	MARYLAN										
Fun Dire			5. Social Security Number 256-54-8375  Usuel Residence of Decedent	7. Ag 1 □ M 2 【X F	ge (In yrs.	Yrs.	If Under 1 You Months De			Dey, Yea		9. Birthpli Count Georg	ace (State by) Gle gia	e or Foreig ennvill
puel a	10	1	10a. State 10b. County		10c. City	y, Town or Lo	ocation					10	d. Inside	City Limits
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with the	Don ad I	Funeral Director	10e. Street end Number 2625 N.E. 34th S	treet			10f. Zip Coo	470		10g. 0	nited	Whet Count Stat	es	
leath	The state of	era	11. Marital Status	12. Was Decedent	Ever in U	S. 13 V			n? (Specify Yes or	No-	-	meric		
s 1 and 2 should be filed within 72 hours efter death with the Maryland if Health and Mentel Hygiane. Itam 27 is marked other than "natural", or items 23s or 28s-f show	Examiner	5	1 Never Married 2 Married  3 ☑ Widowed 4 □ Divorced	Armed Forces	?	1	f Yes, specify ( 1 ☐ Yes 2 🛣		n? (Specify Yes or Puerto Ricen, etc.)		Bled	ck, White, e	etc.	
2 ho	cal	Completed	15. Decedent's			16e. Deced	dent's Usuel Oc	cupetion		16b.	Kind of Bu	usiness/Ind	ustry	
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should be nd Mentel marked o	netic	P	Toy Cobb						Nell Ru					
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ges 1 and 2 nt of Health if item 27 I	ther	-	Cynthia L. Bril 20a. Method of Disposition	1 /Daugnee					et, Ocala	-			470	
Pege nent o	ŏ		1 ☐ Burial 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spec	cify)	Goo	d Sheph		ial Garde	June 2	3 200	ala, Flor	City or Tov Mari ida	on C	ounty
permit. Per Depertmen Important:	any injury once.		21. Signature of Funeral Service Lic	ensee #M0069 J. Course		22	Jenning	ldress of Fecility gs-Archw uthwest	ay Funera 10th Str	al Ho	ome Ocal	a, Fl	344 orid	
			23a. Part1. Enter the disease, or co shock, or heert feilure. List on	mplications that cause y one ceuse on each li	d the death	. Do not ent	er the mode of	dylng, such es ce	erdiac or respiretor	errest,			Approxim Intervel B	ete Between
Physic			Company of the company									1	Onset en	d Death
/Medi Exami	_		Immediate Ceuse (Final disease or condition resulting in death)	e he	10041	a						i	3da	LUS
	-	-	rodding in doddin			r es e conseq	quence of):						3da	
De l	18it	든		b Sc.	end	enua							10 ye	aus
wacu and	el-tra	Examiner	Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury		Due to (or	r es e conseq	juence of):							
siciar	pari	<u>8</u>	ceuse. Enter Underlying Ceuse (Diseese or Injury thet initiated events	o. PU			y perte	usin_				i	2 yes	ars
The law requires that the death certificate be executed allowed has been signed by the ettending physician and		Physician/Medical	resulting in deeth) Lest	d	Due to (or	es a conseq	uence of):					       		
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iras tl signe	28	py							5/7-0			04: 111		as Alexan
e law requiras thet has been signed b	2 should	Completed							24a. W	es en eu erformed?	opsy	con	re eutops lleble pric apletion o leath?	y findings or to of cause
The dete	page	5							1	Yes	2 🗆 No	10	Yes a	No
ician: The			25. Wes cese referred to medical exeminer?					26. Place o	f Death (Check on	ly one)				
2 00		ဝ	1 ☐ Yes 2 No	Hospital: 1 Lanpatio		ER/Outpetien	it 3□ DOA	Other: 4 Nurs	ing Home 5□ R	sidence	6 □Oth	er (Specify,	)	
fe g	Juere		27. Menner of Deeth  1   Neturel 5 □ Pending  2 □ Accident investigat	28e. Dete of Inju (Month, Da	iry ly Year)	28b. Time of Injury		njuryet Work? 1 □ Yes 2 □ No	28d. Descrit	e how In	jury occur	red		
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After	ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not determine		jury - At ho c. (Specify	me, farm, str	eet, factory, off	Ce	28f. Location City or	(Street Town, Ste		er or Rural	Route No	ım <i>ber</i> ,
Hospit     24 hour     Funera	completaly filled in	edicai	29a. Certifier 1 Certifying F	hysicien: To the best iminer: On the basis of end menner st	t examinet	vledge, death ion end/or inv	n occurred et the vestigetion, in m	e time, date end ny opinion, death	place, end due to t occurred et the tin	ne cause le, date e	(s) end me nd place,	enner es ste end due to	eted. the ceuse	e(s)
Vithin of	dwo		29b. Signeture end title of certifier		-		29c. Lic	ense number		29d. [	ate signe	d (Month, E	Day, Year,	)
->-	<u> </u>		Magein	clen			RA	485		Jan	11 72	199	7	
			30. Name and address of person wh	completed ceuse of c	leeth (Item	23e) (Type				Jot	u -/			
			10.			ENE &	T. 84	TIMORE	, Manylo	ud	21201	1		
			VINIT LITICIANU I	32. Registr		ENC 4	11 DA	-111-100	1.20.9					

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Month 30 William Ross West June 3:00 am 4e. Fecility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death 305 West Haven Drive Severna Park Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Aga (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yaar) Birthplaca (State or Foraign Country) Days Hours 187M 2□ F 215-64-3878 45 Yrs Jan. 3, 1952 MDUsual Rasidanca of Dacedent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ₩ No Anne Arundel Severna Park 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 21146 305 West Haven Drive USA 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas ②☐ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indien, Black, White, atc. 1 ☐ Navar Married 2 X Marriad 1 ☐ Yas 2 No Specify: White 3 ☐ Widowad 4 ☐ Divorced 16a. Dacedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retirad) 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highast grade complated) Elemantary/Secondary (0-12) College (1-4or 5+) Engineer Electronics Firm 17. Fathar's Nema (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) William T. West Martha C. Ross 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Karen L. West/Wife 305 West Haven Drive, Severna Park, MD 21146 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cremetory or other place) 20c. Location - City or Town, State Data 1 ☐ Burlal 2 Cramation 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 Other (Spacify) Metro Crematory Catonsville, MD 7/1/97 21. Signature of neral Service Ci 22. Nama and Address of Facility Barranco & Sons P.A. Severna Park Funeral Home 495 Ritchie Hwy. Severna Park, MD 21146 Entar the disaasa, or complications that ceusad tha daath. Do not antar tha mode of dying, such as cerdiac or raspiratory arrest, or haert failura. List only one causa on each line. tatic Squamous Cell Carcinoma
Dua to (or as a consequence of): Immediata Ceusa (Final disaasa or condition rasulting in daath) Five years Sequantially list conditions, if any, laading to immadiate ceusa. Enter Underlying Cause (Disaase or injury that initiated evants resulting in daath) Last Dua to (or as a consequence of): Dua to (or es e consequence of): Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Wera autopsy findings eveilabla prior to complation of ceusa of death? 200 No 1 ☐ Yas 1 ☐ Yas 2 ☐ No 25. Was casa raferred to madical axaminer? 26. Plece of Daath (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetiant 3 ☐ DOA Othar: 4 Nursing Homa 1 Yas 2 No 5 Residance 6 □Othar (Specify) 27. Manner of Death
1 ANatural
2 Accident 28a. Data of Injury (Month, Day Yaar) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding Investigation 1 ☐ Yas 2 ☐ No 6 Could not be datamined 3 Sulcide 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida Learnitying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, end dua to the causa(s) and mannar as stated.

2 Madical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, data end place, and due to the causa(s) and mannar stated. 29a. Certifian (Check only one) 29b. Signatura and titla of certifier 29c. Licanse number 29d. Date signed (Month, Dey, Year)

P.O. Box 68760, Division of Vital Records.

**Physician** /Medical Examiner The law requires that the deeth certificeta be axecuted and usa as the burial-tran ed by the attending physician detached for use as the burie signed by t ceta hes been sig , page 2 should b cartificeta hes or Attending Physician: Aftar this funaral within 24 hours eftar daath.
To the Funeral Director: Al
complataly filled in by tha fu Hospital tha

**Physician** 

/Medical

Examiner

10a. Stata

**Funeral** 

Director

ns 23a or 28a-f show

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Medical Certification:

Pagas 1 and 2 should be filed within 72 hours after death with the Manyland nant of Health and Mental Hygiene.
snt: If Item 27 is marked other than "natural; or hame 23a or 28a-f show ury or other traumetic event, the Medical Examples mant be notified at

Department of Important: If any Injury or once.

permit.

21215-0020

Baltimore, Maryland

State Registrar

0 3 1997

Elizabeth Claure

31. Data filed (Month, Day, Year)

30. Name end address of person who completed ceuse of deeth (Itam 23a) (Type, Print)

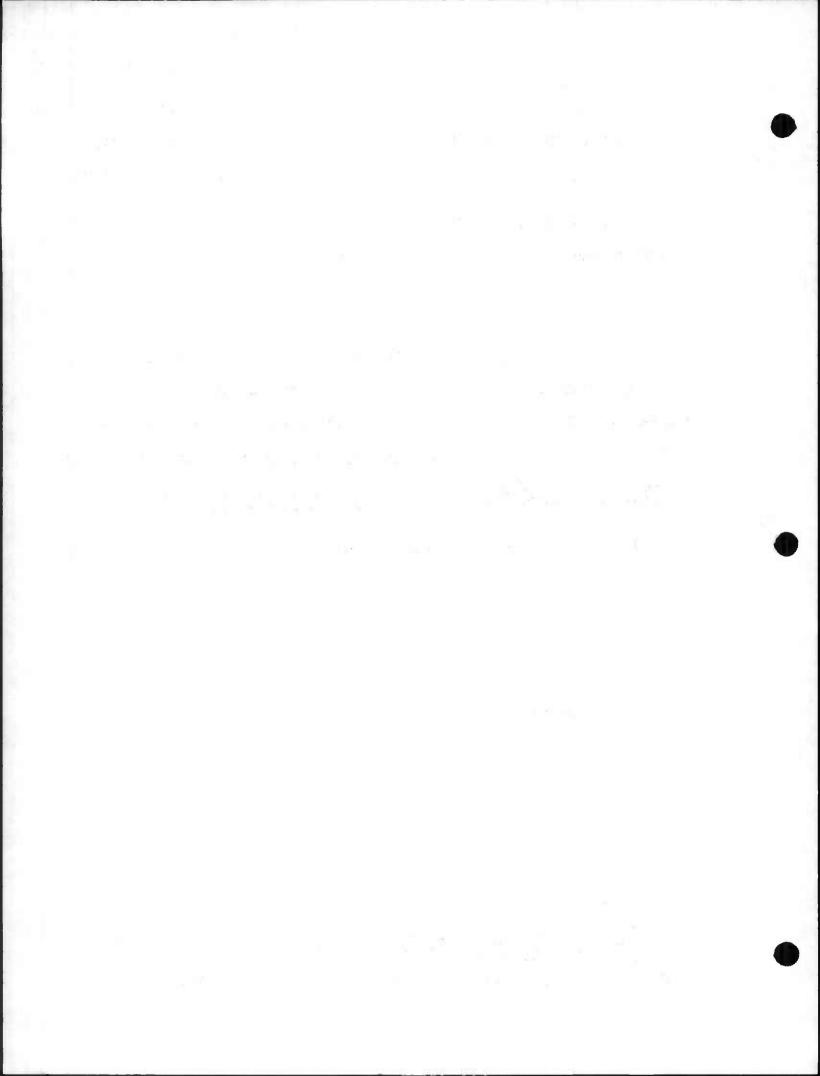
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600 North Wolfe Street Baltimore Maryland 32. Registrer's Signatura Aulia Sevidos

State of Maryland / Department of Health and Mental Hygiene 97

ne 97 21333

_							Cen	tificat	te of	Death			Reg. N	No.			
	Physici /Medi		1. Decedent's Name (First, Midd	(le, Last) GEORGE A.	WHI	TE						2. Dete of De Month JULY	eth	Day 1997	Yeer		me of Death
	/Medi Examir		4e. Fecility Neme (If not institution							4b. City, To	wn, or Lo	ocation of Deet	- 1		y of Deeth	0:	23 alli
	EAGIIII		MILLENNIUN HEA	LTH & REH	AB C	ENTER				GLEN	BURN	ITE			ARUN	DEI.	
	Funeral		5. Social Security Number	6. Sex		In yrs. lest bir	rthday)		r 1 Year	If Under	24 Hrs.	8. Dete of Bir (Month, De					tate or Foreign
	Director		217-07-5002	1⋤M 2□ F		101	Yrs.	Months	Deys	Hours	Min.	MARCH	y, Yea	1r) 396	MARY	ntry)	tate or Foreign
	ס		Usuel Residence of Decedent											330	LILLICI	DITTI L	
	how #	١.	10a. State 10b. County	/	1	0c. City, Tow	n or Loca	ation								10d. Insi	de City Limits
	Ma Ma	Ş	MARYLAND ANNE A	RUNDEL		SEVERNA	A PA	RK								1 🔯	Yes 2□No
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	th wi		3 WHITE ROAD					21	146						US		
	dea	Funeral	11. Maritel Status	12. Was Dec	edent Ev	er in U,S.	13. W	as Dece	dent of I	Hispenic On	igin? (Sp	ecify Yes or No Rican, etc.)	)		ce - Americ		an,
0	or its		1 Never Merried 2 X Mar	rled 1 ☐ Yes	2 XNo							Hican, etc.)			ck, White,		
00	72 hours after death with the Maryland natural; or items 23s or 28s-f show diest Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorce	If Yes, Gi			11	☐ Yes	2LXN0	Specify:				Specif	y: BL	ACK	
2	72 h	Completed	15. Deceder	nt's Education est grade completed)		16e.	Decede	ent's Usu	el Occup	petion during mos	t of work	ina	16b.	Kind of B	usiness/In	dustry	
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3	should be and Mentel in marked or umatic eve	<sup>2</sup>	CHARLES W							ANN	IE G	SILES					
a	2 shows and a market ma		19e. Informent's Name/Relation									al Route Numb				,	
ď.	s 1 end 2 should be filed within 72 hours after death with the Manylen I Health end Mentel Hygiene. If the 27 Is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at		LILLIE MAE WHIT	E (WIFE)						SEVER	NA F	PARK, M	-				
altimore,	des 1		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation	3 □Removel from	State		ry, creme	etory or c	other ple		į	Date	20c.	Location	- City or To	own, Sta	te
<u>E</u>	men men lant: jury		4 Donation 5 Other (5	Specify)		ASBUR	Y TO	WN N	ECK	CEMET	ERY	7/8/97	SEV	VERNA	PAR	К, М	D.
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r			23a. Part1. Enter the disease, o shock, or heert feilure. Lis	r complications that of	caused th	e death. Do	not enter	the mod	de of dyl	ng, such as	cardiac	or respiretory e	rrest,	401		Approx	kimete el Between
ij	Physician	1	one on the order of the order o	only one occase on c	20011 11110.											Onset	end Deeth
	/Medicai		Immediete Ceuse (Final diseese or condition	Cor	onar	y Arte	ry I	Disea	ase							1 :	year
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о. О.	The law requires thet the death as the bear signed by the etten page 2 should be deteched for u	Physiciar	Pert II. Other significent conditi	ons contributing to de	eath but r	not resulting in	n the und	derlying c	ause giv	ven in Pert i		23b. Did	tobeco	o use co	ntribute to	o the ca	use of death?
	het th		Pernicious	s Anemia								1 🗆	Yes	2□ No	3 Pro	bably	4
Ś	signe d be	l by														/2111 - 3.E.	
0	w require been si should	Completed										24a. Was	en eut		ev	ellable p	psy findings prior to n of cause
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Division of Vital	cian	Be	25. Was case referred to medica examiner?								of Deetl	h (Check only	one)				
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Ž	After Uner	on	27. Manner of Deeth 1 ☑ Neturel 5 ☐ Pendir	19	of Injury th, Day Y		rime of njury		28c. Injui Wo			28d. Describe	how in	jury occur	red		
S	Attending Physician: The lav sr death. ector: After this certificate hes by the funerel director, page 2	cat	2 Accident investi 3 Suicide 6 Could	not be				М		Yes 2□							
<u>&gt;</u>	or At	Certification:	4 Homicide determ	ined 288. Place	of Injury ing, etc. (	- At home, fa Specify)	rm, stree	et, factory	y, office			28f. Location ( City or To			ber or Rure	el Route	Number,
_	To the Hospital or Attend within 24 hours efter death To the Funerel Director: completely filled in by the		One Continue ATLO at 1														
	Hos Fun Fun	edical	29a. Certifier (Check only one) Certifyir 2 Medical	ng Physician: To the Examiner: On the ba	asis of ex	aminetion en	, deeth d d/or inve	occurred stigetion,	et the tir , in my c	me, dete en opinion, dee	d place, th occurr	end due to the ed at the time,	date e	(s) end ma nd place,	enner es s end due to	teted. o the ceu	use(s)
	ithin of the	M	29b. Signel serfand title of certifie	end man	nei statet	1.		290	Licens	se number			29d D	ate signe	d (Month,	Day Va	norl
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			21000	2 -3 . 8		1 4 1	V /		וע	7100				07/0	4/91		
			30. Name and eddress of person Harjit Singh	who completed caus	of deet	h (Item 23e) ( •A Rit	Type, Po	rint) E Hic	ahwa	V R	alti	more, M	d	2122	5		
	-0-		31. Date filed (Month, Day, Year)			Signeture			, , , , , ,	·				- 122			
	Sta Registr	_	[] 11	071997	ogisti di	Sign Main	-	Bode	220								
			JUL	U 1 133/	1	- worwie	Carl Series	1									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Mysiene prior to burial, cremation, or removal.	MPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examinar must he marked or name
THE HOSPITAL	THE FUNERAL of filed within 72	MPORTANT: If

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last, 2. DATE OF DEATH 3. TIME OF DEATH ORLANDO ALENTIN CYEAR 00 5:20 PM 2 6. AGE (In yrs. last birthday IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 6. BIRTHPLACE (State or Foreign 218302289 DELAWARE 1 M 2 - F -22-09 0 9b. CITY, TOWN OR LOCATION OF DEATH 9c. CQUNTY OF DEATH arrol DIRECTOR arro minster RESIDENCE OF DE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland SY Kes 1 YES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 710 S. 2178 Bac U. 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 X YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuben, Mexican, Puarto Rican, stc.)

1 □ YES NO Specify: 14. RACE — American indien, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES ΒY 3 Widowed 4 Divorced white COMPLETED 15. DECEDENT'S EDUCATION secilly only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 166. KIND OF BUSINESS/INDUSTRY (Spr Elementary/Secondary (0-12) College (1-4 or 5 +) PHOTOGRAPHY PHOTOGRAPER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Orlando Wootten, Sr. BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 7200 Third Avenue Sykesville, MD 21784 Mrs. Jean Wootten (Wife) 20e. METHOD OF DISPOSITION
1 Burlel 2 M Cremetton 3 Rem 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE 4 ☐ Donetion 5 ☐ Other (Specify) Carroll Cremation Serv. 6/30/97 Hampstead. MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE NAME AND ADDRESS OF FACILITY HOME & CHAPEL (Box 195) Brian Sykesville, MD 21784 (410)-795-1400 23. PART i. Entar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. Approximata interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Bilatera 2 days neumonia resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE Dementi PERFORMED? 1 TES 2 TYNO OF DEATH? Pernicious Anemia 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Inpetient 2 ER/Outpatient 3 DOA OTHER: 1 - YES 2 NO ng Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 26e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) end manner as stated. 2 MEDICAL EXAMINER: Og the ba cured at the time, date and piece, and dua to the ceuse(e) end manner ea stated. 29d. DATE SIGNED (Month, Day, 29c. LICENSE NUMBER BE 34124 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) 30. NAME/AND ADDRESS onn Wson 31. DATE FILED (Month, Day, Year) 32. AEGISTRAR'S SIGNATURE JUN 3 0 1997

WRC 97-3578-015 THOMAS WAYNE WYATT

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 21335

TT			art I,27,28a-f per MEI  1. Decedent's Name (First, Middla, La		dh	Certific	ate of	Death	2. Date of De	Reg. No.		3. Time of Death
	Physic /Medi Examir	cal	THOMAS WAYNE 4a. Facility Name (If not institution, git UNION MEM. H					4b. City, Town, or	JUNE Location of Death	28, 1 4c. County	of Death	10:02 AM
	Funeral Director			Sex 7. Age (In	yrs. last bir 35	Yrs. If Ur Mont	nder 1 Year hs Days	If Under 24 Hrs Hours Min	. (Month, Da	h	9. Birthpli Count	ace (State or Foraign lry) Likton, MD
	Ba-f show	Director	10a. State 10b. County MD TALBOT		c. City, Tow	n or Location					10	Od. Inside City Limits
	72 hours after death with the Maryland natural; or items 23s or 28s-f show deal Examiner must be notified at	Funeral Dire	10e. Street and Number 208 AUGUST STF 11. Marital Status	12. Was Decedent Ever Armed Forces?	in U,S.		Zip Code  216 ecedent of Hespecify Cube		Specify Yes or No to Rican, etc.)	U.S.A  14. Rac Black		an Indian,
21215-0020	d within 72 hours aftiene. r than "natural", or the Medical Exam	þ	1 Never Married 🏖 Married 3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gr.	1 Yes 2 No If Yes, Give Yeer or Dates:	16a.	Decedent's L	s 2 No	Specify:  ation during most of wo	orking	Specify 16b. Kind of B	Whi	
d 2121	illed within Hygiene. ther than int, the we	Completed	Elementary/Secondary (0-12)  12  17. Father's Name (First, Middla, Lasi	College (1-4or 5+)	S	tock	T usa ratire	on .	me (First, Middle,	Grocer		
Maryland	ed at b	To Be	Kenneth Wyatt,	Sr.				unknow	n			
e, Ma	nd 2 selfth ell		19a. Informant's Name/Relationship (Catherine M. Wy	att	20	8 Aug	ust S	St., Ea	ston, M	ID 2160	1	
Baltimore,	8 5 2 0		20a. Method of Disposition  1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spaci	_Hemovai from State			Ceme	etery	Date 7/3/97	Easton		
Bal	pemit. Page Depertment of Important: If any Injury or once.		21. Signature of Funeral Service Lice	MERCERO	2	Fell	ows, F		ein, &			eral Home
	Physician /Medical Examiner	Je.	23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. PROPOXYPHEN	NE INTO		l .	g, such as cardia	c or respiretory e	rest,	1	Approximate Interval Between Onset and Death
Box 68760,	oxecuted executed in end intransit		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		consequence						
P.O.	death e ette rd for	Physician/Medical	Part II. Other algnificant conditions of	contributing to death but no	t resulting in	n the underlyir	ng cause giv	en in Part I.		tobacco use co Yea 2□ No		the cause of death?
Records,	aw requires to been signated to should be	Completed by								an autopsy rmed?	con	re autopsy findings ilable prior to apletion of ceuse eath?
	The ete h	Be Corr	25. Was case referred to medical					26. Place of De	ath (Chack only o	res 2□No	112	Yes 2□ No
ion of Vital	ng Phys fter this ineral di	ဥ	examiner?  1XI Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Yas	28b. 7	itpatient 3   Time of Anjury A	28c. Injur Wor	er: 4 🗆 Nursing I	Home 5 ☐ Resid			)
Division	To the Hospital or Attendi within 24 hours efter deeth. To the Funeral Director: A completely filled in by the fi	i Certification:	3 ☐ Suicide 60X Could not be determined	28e. Place of Injury building, etc. (Sp at residence	At home, fa	rm, street, fac			Earlsvill	e, Maryla	nd	Routa Number, Cove Road,
	he Hospin 24 hohe Fund	edicai	29a. Certifier 1☐ CertifyIng Ph (Check only one) 2☑ Medical Exam	nysician: To the best of my miner: On the basis of exar end manner stated.	knowledge mination and	, death occuri d/or investigat	red at the tin tion, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place,	anner as sta and due to	ited. the cause(s)
	To the com	M	29b. Signature and title of certifier	4 King.	~		29c. Licens	o . C . M		29d. Date signe JUNE 29		* * * * * * * * * * * * * * * * * * * *
			30. Name and address of person who		(Item 23a) ( 111	(Type, Print) Penn	Str	eet, Ba	ltimore	e, Mary	yland	1 21201
	Sta		31. Date filed (Month, Day, Yaar)	32. Registrar's S	Signature	, Egg	W 15					

State of Maryland / Department of Health and Mental Hygiene

							(	Certif	ficate of	Death	•	Reg. No.		21000
	1		1. Decedent's Name (Firs	t, Middla, La	ist)				- 5		2. Data of De	eth		3. Time of Death
	Physici /Medio		Stanley	L	INGO			Wi	lliams	SR	June	21 Day	199 <sup>×</sup>	10:55 PM
1	Examir		4a. Facility Nama (If not in	stitution, giv	re street end numbe	r)		_		4b. City, Town, or	Location of Deat	h 4c.	County of Deetl	h
			Salisbury C	enter	: Genesis	Elde	rcar	e	;	Salisbury	, MD	W	icomico	
	Funeral		5. Sociel Security Number			Aga (In yrs.	last birth		f Under 1 Yaar lonths Deys		8. Date of Bir (Month, De	th Year	9. Birtl	hplace (Stete or Foraign untry)
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	pu 🛾		Usual Rasidance of Dece 10a. Stata 10b.	dant County		10a Cit	y, Town	or Locati				-		40.1.1.00.1.0
	aho	5		Wicom		100. 01								10d. Inside City Limits 1 ☐ Yas 2 ☑ No
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	with with		608 Terrap	in Tar	3.0				10f. Zip Coda	804	:		zen of What Co	untry?
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_	Hen	ä	1 Never Married 2	X Married	Armed Force	s?	,3.	If Ya	as, specify Cub	rlispanic Origin? (S en, Mexican, Puart	o Rican, atc.)		Black, White	
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b	be liled ntel Hygie d other	Bec	17. Fathar's Nama (First, I	Middle, Last	)	-				18. Mother's Nar	na (First, Middle	, Melden	Sumeme)	
<u> a</u>	0 = 0 e	ToE	John A. Wi	11iams	S					Emma	Gibbons			
Maryland			19e. Informant's Name/Re	alationship (	Type, Print)		19b. N	Mailing A	Addrass (Streat	and Number or Ru	ral Route Numb	er, Clty o	r Town, Stata, Z	(ip Code)
	and alth		Frances M.	Will:	iams/wife			608	Terrap	in Lane,	Salisbu	ry,	MD 2180	4
ore	ges 1 and 2 t of Health if item 27 is or other tra		20a. Mathod of Disposition 1 🛣 Burial 2 □ Cran		]Dames   16 04 04		lece of Damatary,	Disposition cremate	on (Nama of ony or other ple	ce)	Dete	20c. Lo	cation - City or	Town, Stata
Ĕ	Pages nent of h ant: If its ury or or		4 Donation 5 DO				verg:	reen	Cemet	ery	6/25/97	Be	rlin, M	D
Baltimore,	permit. Page: Department of Important: If I any Injury or RISCS.		21. Signature of Funeral S	Service Licer	1586	MOI	051		eme end Addra					
ш.	88188		De la vil	) 21	Comoso					y Funeral		- l	MD 3:	100/
	110		23a. Part1. Enter the dise shock, or heart failur	asa, or com	plications that caus	ad tha daat	h. Do no	t enter th	ha moda of dyi	W Hill Rd ng, such es cardiad	or raspiratory a	rrast,	y, MD 2	Approximata
V.	Physician	ı	aroot, or nour lange	a. List offiy									0 1	Intarval Between Onset and Death
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	The law requires that tha death certificate be executed the has been signed by the ettending physician and page 2 should be detached for use as the bunel-transit	Examiner	Saquentially list condition	s,	D	Dua to (o			nce of):					
90,	sian e		Saquentially list condition if eny, laading to immedia causa. Enter Underlying Cause (Diseasa or injury	Ita	0									
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	entifica ding p	Me		L	d									
Вох	ath c	lan												
<u>о</u> .	es that tha daath cer igned by the ettendir be datached for usa	Physician/M	Part II. Other significant of	ondittons o	ontributing to death	but not ras	ulting in t	ha undai	rlying causa gi	ven in Part I.	23b. Did	tobacco	uss contribute	to the cause of death?
	hat the by detac	P.	Congesta	ie /	CAST	Cos	len	2			1 🗆	Yes 2	ØNo 3□Pr	obably 4 Unknown
Records,	sign d be	d by				^	_		0		040 11/00		24b V	Mara autoney findings
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	cete		Ceff u	ip	1 N FORCE	NON					1 🗆	Yes 2	ZN0 1	☐ Yes 2 No
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ot	hysi this al dir	5	1 Yas 2 No		1 ∐ Inpa	tiant 2			3LI DOA			-	6 □Othar (Spec	cify)
Division of Vital	Attending Physician: or deeth. ector: After this certific by the funaral director,	Certification:	1 Natural 5 🗆	Panding	28e. Data of In (Month, L	ay Year)	28b. Tin Inju	ury	28c. Inju Wo		28d. Dascribe	how injur	y occurred	
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<u> </u>	or A after Direction by	Tie	4 Homicide	datarminad	28e. Placa of I building,	atc. (Spacif	y)	1, SUBBL,	ractory, onica		City or To	wn, Stata	)	ral Routa Number,
	To the Hospital or Attending Physician: The law within 24 burus after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifiar 1□ €	ertifutna Ph	ysicten: To the bes	t of my kno	udodoo o	death oo	ourred at the ti	mo data and place	and due to the	001100/0)	and manner on	ntoted
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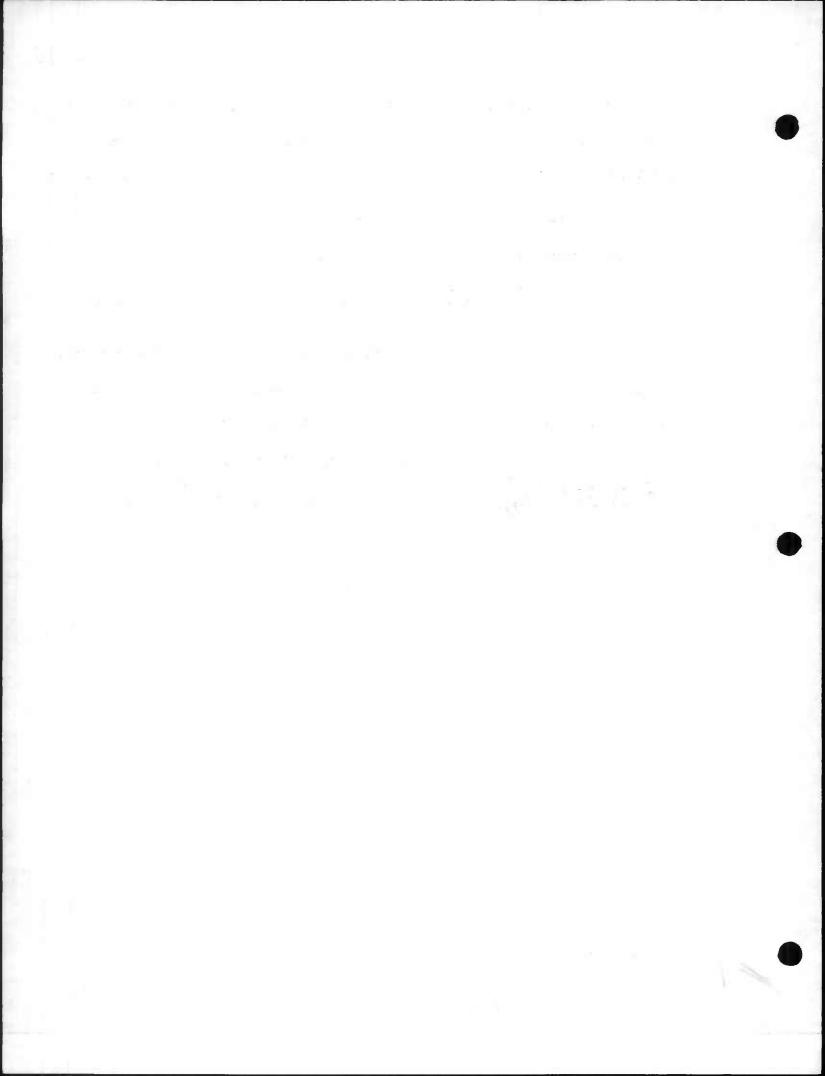
DHMH 16 Rev 6/95

				C	Certificate	of Death		Reg. No.		
1		1. Decedant's Nama (First, Middla, Li	ast)				2. Date of D	eath		ma of Death
Physi		Roy THOM	AS		w.i.	lley J	Month June	24 1 <sup>9</sup>	997 10	:35 PM
Exam	dical niner	4a. Facility Name (If not institution, gi					wn, or Location of Dea			. 55 111
		Salisbury Center	: Genesis Eld	erCare	2	Salish	oury, MD	Wicor	mico	
Funera	al	5. Social Security Number 6.	Sax 7. Age (In	yrs. last birtho	(ey) If Under 1			irth	9. Birthplaca (S	iteta or Foraig
Directo	or	216-48-6015	1XM 2□ F 48	Yn	S. WIOTHIS L	ays nours		r 26,1948		
p >		Usual Rasidance of Dacedant	140-	04. ****	-1 0					
anyla	_	10a. Stete 10b. County		City, Town o	r Location					ide City Limits
Ba-f	octo	Maryland Wicom	ico	Sali	sbury					Yas 2□No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show any Injury or other traumatic event, the Medical Examiner must be notified at	Director	10e. Street and Number			10f. Zip Co			10g. Citizen of \	What Country?	
ath v	ē	608 Zion Road				21804		USA		
er de	Funeral	11. Merital Status	12. Was Dacedant Evar i Armed Forces?	n U,S.	<ol> <li>Was Dacedan If Yes, specify</li> </ol>	t of Hispanic Ori Cuben, Maxicar	gln? (Specify Yas or N i, Puarto Ricen, atc.)	o- 14. Rac Blac	ca - American Ind ck, Whita, atc.	an,
or l	by F	1 Never Marriad 2 Merried	1 ☐ Yas 2 ☑ No If Yes, Giva		1 ☐ Yes 2 🖸	No Specify:		Specify	V: Uhit	
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be f d of	Be	Roy thomas Wi	•						,	
Mer Merke	은						nna Marga		rrison	
2 st and and Is m		19a. Informant's Name/Ralationship					er or Rural Route Num		Stata, Zip Coda;	
and lealth m 27		Bonnie Jean Wil					lisbury, M			
Jes Tof If Ita		20a. Mathod of Disposition  1 Dunial 2 Cremetion 3 D		cemetery,	isposition (Nam <i>e</i> cramatory or otha	r place)	Deta		- City or Town, St	ata
men ant:		4 □ Donation 5 □ Other (Spedi		alisbu	ry Crema	atory	6/28/97	Salist	oury, MD	
pont bout	buce	21. Signature of Funeral Service Lose	nsee			ddress of Fecilit	•			
8075	ä	1118 111	Umn			-	eral Home	å a b	MD 2100	
-3-6-		23a. Rax1. Enter tha disaase, or consolock, or heart failure. List only	nplications that pursed the o	laath. Do not	antar tha moda o	f dying, such as	1 Rd., Sal cardiac or raspiratory	arrast,	Appro	ximata
Physicia	n /	snock, or haart failura. List only							Onse	al Between and Death
/Medica	_	Immadiata Causa (Final	· Lung	- 1	- A	1071101	ATO TO	Ron	151	nonth
Examine	er	disaasa or condition resulting in death)	a. Lung	0/01/05/0000	nsaquance of):	47731	17110 10	131477		
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exec an an rial-tr	Ä	Sequantially list conditions, if any, leading to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury		(0. 40 4 00.						
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State Registrar

State of Maryland / Department of Health and Mental Hygiene 97

						Ce	rtificate of	Death	F	Reg. No.		21000
	DI II		1. Decedent's Name (First, Middle,	Last)					2. Dete of Dee Month	ith	Veer	3. Time of Death
	Physic /Medi		Ernest	Edward		1	Vibben		June	18 1	L 997	3:35 P.M
)	Exami		4a. Fecility Neme (If not institution,	give street and number)				4b. City, Town, or L	ocation of Deeth	4c. County	y of Deeth	
			30344 Calh	oun Dr.				Salisbu	ıry	T.	Vicom	ico
	Funeral Director		5. Social Security Number 043-12-4147 Usuel Residence of Decedent	5. Sex 7. Ag 1 X M 2 □ F	e (In yrs. les	t birthday) Yrs.	If Under 1 Yea Months Deys		8. Date of Birth (Month, Dey May 28	(, Year)		plece (State or Foreign intry) necticut
	yland		10e. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Mar Bet si	to	MD Wice	omico			Salisbu	ry				1 ☐ Yes 2 🎇 No
	or 28	ire	10e. Street end Number				10f. Zip Code		1	10g. Citizen of	Whet Cou	intry?
	th wi	aic	30344 Calh	oun Dr.			21	804		U	J.S.A	
	ems ems	Funeral Director	11. Maritel Status	12. Was Decedent Armed Forces?	Ever in U,S.	13.	Was Decedent of	Hispenic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No-		ce - Ameri	ican Indien,
0200-01212	within 72 hours after death with the Maryland ene. than "neturel", or items 23a or 28a-1 show ita Modical Examiner must be notined at	þ	1 ☐ Never Married 2 🙀 Marrie 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 If Yes, Give Year or Dates:	NoNavy WWll		1□ Yes 2⊋ No		rnoan, etc./	Specif		
ה	d 2 should be filed within 72 hours th and Mantal Hygiene. 7 Is marked other than "neturel", traumatic event, tra Modical Exa	Completed	15. Decedent's (Specify only highest	Education grade completed)		16e. Dece	dent's Usual Occu	upetion e during most of work	rina	16b. Kind of B	usiness/In	ndustry
7	12 should be filed within h and Mantal Hygiene. I's marked other than " traumatic event, the Mos	npie	Elementary/Secondary (0-12)	College (1-4or	5+)			e during most of work red)				
	ygier ygier her th	S	12			Auto	omobile	Dealership				ployed
Maryland	be fi	Be	17. Fether's Name (First, Middle, Lo	rt'				18. Mother's Nam	e (First, Middle,		16	
Ž	ould Mar Marke	1º	Ernst		Wibben			Sophie			Schre	
2	2 sh and Is rr		19e. Informent's Neme/Relationshi					et end Number or Rui				
	1 and 1 Health em 27 I		Barbara M. Wil	oben - wire	COL Dia		J344 Call	houn Dr.	Salisbu			
altillore,	2 5 5		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donetion 5 ☐ Other (Spe		cem	etery, crer	netory or other pl	y Gardens	-30	Hebro	,	
Da	permit. Page Department of Important: If any injury or once.		21. Signature of Funerel Service Li	ensee P	DES		2. Name and Add	ress of Fecility uneral Hon		E. Mai		-
			23a. Pert1. Enter the disease, or c shock, or heart failure. List or	omplications that ceused	the death.						1110	Approximete Intervel Between
	Physician		Shock, or heart failure. List of	ily one cause on eech li	ne.						1	Intervel Between Onset end Deeth
	/Medical		Immediate Ceuse (Finel disease or condition	Card	200	2	+				1	
	Examiner		resulting in death)	a. Cuch	Due to (or e						<u> </u>	Merce
à		je		Oaks	0 50	3 0 0011300	B. S. 11	10.0.0			17	i mo
	outed	Examiner	Sequentially list conditions	b. 2007C	Due to (or a	s a consec	juence of):	a dieday	4		1	, ,,
5	an ar urial-t		Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury	Gr. des	25.50	00	al mana	a. E. F.	mus			6 mo.
50000	entificate be executed ding physician and se as the burial-transit	Medical	that initiated events resulting in death) Lest	c. date	Due to (or as	s e conseq	uence of):					<u> </u>
	a death cer he attendin led for use	Physician/	Part II. Other eignificent condition	contributing to death b	ut not resultir	ng In the u	nderlying ceuse g	jiven In Pert I.	23b. Did to	obacco use co	ontribute t	to the cause of death?
	as that tha de igned by the s be detached	by Phy							1□ Y	es 2 No	3 □ Pro	obably 4 Unknown
100001	s been s 2 should	Completed t							24e. Was e perfor		ev	Vere eutopsy findings veilable prior to ompletion of cause f death?
	The la ate ha	Son							1 □ Y	es 2 No	11	☐ Yes 2☐ No
	certifical rector, p	Be	25. Was cese referred to medical examiner?					26. Place of Deel	h (Check only or	ne)		
	S 0 0	P	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 EF	VOutpatier	t 3□ DOA O	ther: 4 Nursing Ho	me 5 Resid	ence 6 □Ott	ner (Speci	ify)
	De le		27. Manner of Death  1 Neturel 5 □ Pending 2 □ Accident investiga	28a. Date of Inju (Month, De	ry y Year) 28	Bb. Time of Injury	W	ury et ork? □ Yes 2 □ No	28d. Describe h	ow injury occur	rred	
	i Sitte	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of Injuding, etc.		e, ferm, str	eet, factory, office	•	28f. Location (S City or Town		ber or Run	al Route Number,
	Hospit 4 hour Funera taly fills	edical C	29a. Certifier (Check only one) Certifying 2 Medical Ex	Phyelclan: To the best of aminer: On the basis of end menner sta	examinetion	dge, death end/or inv	occurred et the trestigation, in my	time, dete end plece, opinion, deeth occur	end due to the c red at the time, d	euse(s) end me late end place,	enner es s end due t	steted. to the ceuse(s)
	within 2 To the	M	29b. Signature and title of certain	The state of the s			29c. Licer	nse number	2	29d. Date signe	ed (Month,	Dey, Yeer)
	->-0		Diver		1		7	04883		00 -	10.	97
	Jak 1		30. Name end eddress of person W	no completed according	ooth /lless or	30) /Turn-	Drint\	U9883		06 -	14-	7/
13	er		HILDA F. H		oom (nem 2	oe) (Type,	1000	04883 S. Divi	2 (20)	+ S.	00 1 2 1	himi
1	Sta	to	31. Date filed (Month, Day, Yeer)	32. Registra	ar's Signature	0	1405	3. 5101	2 (Oh 8	1 31	nes	Wind of the second
	Registr		JUN 19	1997 Julia	ar's Signatur	rhand	all					)



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97

						Certifica	ate of	Death	R	eg. No.	,	
	Physic	an	1. Decedent's Name (First, Middle, L	ast)					2. Dete of Deet Month	-	Yeer	3. Time of Death
	/Medi		George Will		n				June 2			8 P.M
ġ.	Examir	ner	4e. Fecility Neme (If not institution, g					4b. City, Town, or		4c. County		1
L			23420 Head Of			H I Ind	er 1 Year	Quantic  If Under 24 Hrs.			omic	
	Funeral Director		5. Social Security Number 6.  220-26-2848  Usuei Residence of Decedent	Sex 1 M 2□ F 7. Age (In 64	yrs. last birt	Yrs. Month		Hours Min.	8. Date of Birth (Month, Dey, Sept. 1	<sup>Year)</sup> 0 1932	9. Birthple Count Mal	ece (Stete or Foreign ry) ryland
	/lend		10e. Stete 10b. County	100	. City, Town	or Location					10	d. Inside City Limits
	Mary	to	Maryland Wico	mico	Oua	ntico						1 ☐ Yes 2 No
	h the	Directo	10e. Street end Number		~		ip Code		1	0g. Citizen of W	/het Count	ry?
	th will		P.O.Box 27			2	1856			U.S.	A	
20	Juithin 72 hours efter death with the Marylend jiene. r then "neturet", or Items 23e or 28s-f show the Medical Exercites frant be notified at	by Funeral	11. Meritel Status  1 Never Merried 2 Married  3 Widowed 4 Divorcad	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give	in U,S.		edent of I becify Cub 2 No	dispenic Origin? (S en, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)		- America k, White, e	etc.
8	hour fural	8	15. Decedent's	Year or Dates:	160	Decedent's Us	ual Occur	notion		16b. Kind of Bu	Bla	
5	in 72 "net redict	Completed	(Specify only highest g	rede completed)	100.	(Give kind of v	vork done use retire	during most of word)	rking	100. Kind of Bu	SITIOSSITIO	ustry
27	s within jiene.	E	Elementery/Secondary (0-12)	College (1-4or 5+)		Labor		,		None	е	
Maryland 21215-0020	int the	BeC	17. Father's Neme (First, Middle, Las	st)				18. Mother's Nar	ne (First, Middle, M	Aeiden Sumem	e)	
<u>a</u>		To B	William Thoma	s Wilson				Evelyn	Perry			
and	S P E E		19a. Informent's Neme/Relationship		19b.	Mailing Addre	ss (Street	end Number or Ru		City or Town,	Stete, Zip	Code)
	5 8 8 5		Jacqueline Wil	son (Wife)	P.	O.Box	27	Quantic	o, Md.21	856		
Baltimore,	oemit. Pages 1 and Department of Healt Important: If item 21 any Injury or other once.		20a. Method of Disposition	20	b. Plece of	Disposition (Ny, cremetory or	eme of other pla	ca)	Dete	20c. Location -	City or Tov	vn, Stete
Ĕ	Pages nent of I int: If ite ury or of		1 Burial 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spec	ify)				Meth.Ce	m . 6/28	Quan	tico	.Md.
a	permit. Pa Departmer Important: any Injury once.		21. Signeture of Funeral Servica Lice			22. Name	end Addre	ess of Fecility		2		,
m	8 9 E 8 8		Hlady B.	Stewart				Funeral Rd.Sal		Md 21	801	
			23a. Pert1. Enter the disease, or conshock, or heart failure. List only		death. Do n	not enter the m	ode of dyi	ng, such es cardie	or respiretory erre	est,		Approximate Intervel Between
	Physician		onoon, or nount satisfie. List of it	y one couse on each line.								Onset end Death
). 	/Medical		Immediete Ceuse (Final disease or condition	tanco	2010	C	2010	19.2				2 ma
	Examiner		resulting in death)	Due	to (or es e o	consequenca o		4				0 1
	p it	Examiner		Malus	Som	N60	(				1	5m2.
	ecute and -trans	каш	Sequentially list conditions,	0.	o (or es e c	onsequence of	f):				1	
20	cian cian	E	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	c								
68760,	tificate be executed ig physician end as the burlal-transit	Physician/Medical	thet initiated events resulting in deeth) Lest	Due t	o (or es e c	onsequence of	):					
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gox	ath	ian									1	
7. O	he de ched	ysic	Part II. Other significant conditione	contributing to death but not	resulting in	the underlying	cause giv	en in Pert i.	23b. Dld to	bacco use con	tribute to	the cause of deeth?
	that t ed by dete								1 🗆 Y	s 2□No	3 Prob	ably 4 ☐ Unknow
Records,	w requires that the designed by the or should be deteched	Completed by							24e. Wes a perform		eva	re eutopsy findings ileble prior to apletion of cause leeth?
	The law ate hes b page 2 s	E O							1 □ Ye	s 2 No		Yes 20 No
Z Z		0	25. Was cese referred to medical					26. Place of Dec	eth (Check only en			
>	Physicien: this certific ral director,	To B	examiner? 1 Yes 2 No	Hospitel:	2 🖒 ER/Out	tpetient 3 0	OOA Oth	ner.	lome 5 Reside		er (Specify	)
ion of	Attending Ph or death. Octor: After thi by the funeral		27. Menner of Death  1 DNaturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Yea	28b. T	`	28c. Inju		28d. Describe ho			
Division	P S S S	Certification:	3 Suicide 6 Could not determine		At home, far ecify)	rm, street, facto	ory, office		28f. Location (St. City or Town	reet end Numbe , State)	er or Rurel	Route Number,
	To the Hospital or within 24 hours efter to the Funeral Director completely filled in	edicai	29a. Certifier 1 CertifyIng P (Check only one) 2 Medical Exa	hysician: To the best of my miner: On the basis of examend manner stated.	knowledge, ninetion end	deeth occurre Vor investigation	d at the tir on, in my d	me, date end plece opinion, deeth occu	, end due to the co rred et the time, da	euse(s) and ma ate end place, a	nner as sta ind due to	ated. the ceuse(s)
	To the To the Comp	ž	29b signature end title of certifier			2	9c. Licens	se number	5	Date signed	(Month, E	Dey, Year)
			ma or La	en les			100	D638	10	well	00	
,			30. Name and address of person who	completed cause of death	(Item 23e) (	Type, Print)	0 1			Ab.	4	
	1/		1560 R	verside D	E 3	606	20	nud296	In	918	01	
	Sta	te	31. Date filed (Month, Day, Year)	32. Begistrer's S	ignature	0			1			
	Registr	ar	JUN 24	139/ John 2014	musera	artall						

Registrar

State of Maryland / Department of Health and Mental Hygiene 97 21340

						Certificate of	Death	R	eg. No.	-	213	
П	Physic	an	1. Decedent's Neme (First, Middla, La	•				2. Dete of Deat Month	Dey Y	/ear	3. Time of	
Ų.	/Medi		DOROTHY LOREN					JUNE		997	9:50	AM
ł	Examir	ner	4a. Fecility Neme (If not institution, git				4b. City, Town, or L		4c. County of			
-			WICOMICO NURSIN  5. Social Security Number 6.5		e (in yrs. iest birt	hdev) If Under 1 Yee	SALISB r If Under 24 Hrs.		WICC			E 09.11
	Funeral Director			1□ M 2X F		Yrs. Months Deys		8. Dete of Birth (Month, Dey, JAN. 1,	Year) 1913		lece (Steta or try) D.	r Foreign
	yland		10e. Stete 10b. County		10c. City, Towr	or Location				1	0d. Inside Cit	ty Limits
	a Mar	Director	MD. WICO	MICO	HEI	BRON					1 🗆 Yes	<b>¾</b> □ No
	t 2 2	Dire.	10e. Street end Number			10f. Zip Code		1	0g. Citizen of Wh	et Coun	try?	
	ath w 23e	E .	106 RAILROAD			1	1830		U.S.	Α.		
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5-0	"natural",	sted	15. Decedent's E (Specify only highest gr	ducation	16a.	Decedent's Usuel Occu (Give kind of work done	petion	rina	16b. Kind of Busi	ness/Inc	lustry	
121	within lana. than "	Completed	Elementery/Secondery (0-12)	College (1-4or 5	+)	life. DO NOT use ratin	9d)					
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ary	d 2 should th and Man 7 is marks traumatic	스	19e. Informent's Neme/Relationship	Type, Print)	19b.	Meiling Addrass (Stree		ETH HUMP		eta, Zip	Code)	
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ore	of Haalt of Haalt I Itam 27 r other		20e. Method of Disposition	Demoval from Chate	20b. Place of cematar	Disposition (Name of y, cremetory or other pic	ece)	Date	20c. Location - Ci	ity or To	wn, Stete	
Ē	mit. Pagas bartmant of I cortant: If its injury or or		1 ☑ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 3 ☐ Other (Special			BRON CEMETA	77.1	20 97	HEBRON,	MD.	,	
Baltimore	permit. Pag Department Important: I eny injury o		21. Signature of Funerel Service Lice	1586	8	Name end Addr	ess of Fecility				21	.804
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	Physician /Medical Examiner	er	Pent1. Enter the disease, or com shock, or heart feilure. List only Immediate Ceusa (Finel disease or condition resulting in death)	. tex	MINA	10	MO NY)				Approximete Intervel Betwonset end D	Deeth
Box 68760,	eath certificate be axecuted attanding physician and for use as the bunel-transit	in/Medical Examiner	Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest	· P	Due to (or es e c		eding	_		KIL	sday mKr	0
B	0 0 2	sicie	Pert II. Other significent conditions of	ontributing to death bu	it not resulting in	the underlying cause g	iven in Pert I.	23b. Did to	bacco use contr	ibute to	the cause o	of death?
P.O.	\$ 50 B	Physician/N			_				100	Prot		Unknown
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/ita	clan: artific setor,	Be	25. Wes case referred to medical examiner?				28. Place of Deet	h (Check only on	a)			
of	\$ 50	<sup>2</sup>	1 ☐ Yes 2 ☐ No	Hospitel: 1   Inpatier		petient 3 DOA		ome 5 Reside			)	
Division	Attending Physician: Ir death. ector: After this cartific by the funeral director,	Certification:	27. Menner of Deeth  1 CNeturel 5 Pending 2 Accident investigation			ijury Wo	iry at ork? ] Yes 2 □ No	28d. Describe ho	w injury occurred			
DIX.	tal or Att is after d al Direct ed in by	Certifi	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide detarmined		rry - At home, fer . (Specify)	m, street, fectory, office		28f. Location (St. City or Town	reet end Number , Steta)	or Rura	Route Numb	ber,
	To the Hospital or Attending Ph within 24 hours aftar daath. To the Funeral Director: Aftar thi completaly filled in by the funeral	edical	29a. Certifier (Check only one)  1 🔀 Certifying Ph 2 🗆 Medical Exam	yeician: To the best of niner: On the basis of end menner ste	examinetion end	death occurred et the t Vor invastigetion, in my	ime, dete end place, opinion, deeth occur	end due to the cared et the time, de	use(s) end menn ete end piaca, end	er es st d due to	ated. the cause(s)	)
	To the To the Comp	Σ	29b. Signeture end title of cartifier			29c. Licen	se number	25	9d. Date signed (	Month, I	Dey, Year)	
			my	777		30	2026		une 10	1-0	17	
			30. Name end eddrass of person who	completed cause of de	eath (Item 23e) (				10 00	1	1.	
			FEDERICO G. ARTI	HES, MD	1622A C	CEAN PINES	BERLIN	, MD 218	11			
	Sta Registr		31. Dete filed (Month, Day, Yeer) 9	1997 32. Bertin	r's Gignelyre	Rardall						

DHMH 16 Rev 6/95

n \* a's a

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month R. 1.30 AM. Henry Uly 4a. Facility Neme (If not institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Deeth SILVER SPRING MONTGOMERY If Under 1 Year 8. Date of Birth (Month, Day, Year) OCT - 31 , 1924 7. Age (In yrs. last birthday) If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 1**万** M 2□ F Months Days 72 Yrs. MARYLAND Usual Residenca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MONTGOMERY SILVER SPRING 1X Yes 2 □ No 10f. Zip Code 20784 10g. Citizen of What Country? 2501 MUSGROVE RD. USA 12. Was Decedent Ever in U,S. Armed Forces? 1 □Xes 2 □ No If Yes, Give Year or DateNWII Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorcad WHITE Decadent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FOOD BUTCHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) BERKOWITZ ARENBERG IDA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9507 RED RAIN PATH COLUMBIA, MD 21046 MRS. BETSEY A. GIBBS (DAUG.) 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BETH JACOB ANSHE VESHEAR 7/13/97 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) uneral Service Lice 22. Name and Address of Facility BROS., INC. wa 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete intervel Between Onset and Death LOUIS Due to (or as a consequence of): Due to (or as a consequenca of): Part II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings evaileble prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature and title of certified 29c. License number 29d Date signed (Month, Day, Year)

Examiner **Funeral** Director

**Physician** 

/Medical

MANOR CARE 5. Social Security Number

219-14-0046

10e. Street end Number

1.1

11. Maritel Status

**HERMAN** 

21. Signature of

20a. Nethod of Disposition

Immediate Cause (Final

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident 3 Suicide

4 Homicide

29a. Certifier

disease or condition resulting In death)

10a. State

Director

Funeral

þ

Completed

Be

2

permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Depertment of Health and Mentel hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 ahreaping injury or other traumatic event, the Martine 2000.

Physician /Medical

**Examiner** 

Examiner ettending physician end i for use es the buriel-transit The lew requires that the deeth certificate be executed P.O. Box 68760. Physician/Medical signed by t Records, þ cete has been sig Be Completed certificate Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Fureral Director: After this certifice completely filled in by the funeral director, is

Medical Certification: To Registrar

Jenny Y. May 31. Date filed (Month, Day, Year) State JUL 1 5 1997



402 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) .

State of Maryland / Department of Health and Mental Hygiene

		I	TEM# 5 PER F.H. FLM#G749 7/24/97 J.A.	Certificate of	Death	Re	g. No.	61074
Physicia /Medica		an	1. Decedent's Name (First, Middle, Last)  THELMA—  AUSTIN			Date of Death Month	Day Year	3. Time of Death 10:48pm
			THELMA AUSTIN  4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or Locat	tion of Death	4c. County of De	
7	Examir	ner	SINAI HOSPITAL OF BALTIMORE		BATIMOR		4c. County of De	Δ
	Funeral Director	uneral 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1			If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day,		irthplace (State or Foreign Country) VA
	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mantal Hygiana. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, ite Medical Examinat must be notified.			Town or Location				10d. Inside City Limits
		Director	MD N/A BALT	TMORE				1 ☑ Yes 2 ☐ No
			10e. Street and Number	10f. Zip Code		10	g. Citizen of What C	Country?
		era	2520 CYBURN AVENUE	2	215		US	Α
21215-0020		by Funeral	11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 Yes 2 No If Yes, Give Yeer or Dates:	13. Was Decedent of H If Yes, specify Cube 1 ☐ Yes 2 ☑ No	lispanic Origin? (Specifi en, Mexicen, Puerto Ric Specify:	y Yes or No- can, etc.)	Black, Wh	nericen Indian, lite, etc.
5-0		Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occup	ation during most of working	10	6b. Kind of Busines	
121		mpie	Elementary/Secondery (0-12) College (1-4or 5+)	life. DO NOT use retired	d) -		T. V	1 (
			8 TH GRADE 17. Father's Name (First, Middle, Last)	HOUSE KEEP	18. Mother's Name (F	First. Middle. Ma	aiden Sumame)	( 6 4) 0
Maryland		To Be	IRAVIS SMITH		- 7	ONES		
		-	19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street	and Number or Rural R	Route Number,	City or Town, State,	Zip Code)
-	1 and 2 Health am 27 i		ANWAR MUHAMMAD SON	2520 (YBURN)	AVENUE, B	BALTO, I	MD 212	15
Ore	P et tr		20a. Metriod of Disposition 20b. Place 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ce of Disposition (Name of netery, crematory or other place	1 1	Date 20	Oc. Location - City of	
Baltimore			4 □ Donation 5 □ Other (Specify)	RISON TOREST		5/97 0	WINGS M	lius, MD
Ba	permit. Pa Departmen Important: any Injury		22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO NATL PIKE BALTO MD 21229					
			23e. Part 1. Enter the disease, or complications that caused the death. shock, or heart fullure. List only one cause on each line.	Do not enter the mode of dyin	ng, such as cardiac or re	espiratory arres	st,	Approximate Intervel Between Onset and Death
	Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting In death)  a. 5055						5.05.4.05.54.0
	tificate be axecuted g physician and as the bunal-transit	Jer	Due to (or es a consequence of):					
		Examiner	Sequentially list conditions,					
90,	oe axe clan a		Ceuse (Disease or Injury thet initiated events resulting in death) Last Due to (or es e consequence of):					
68760,	cata l physi	edicai						
	in Horpital of Attending Physician: The law requires that the death certificate has been signed by the attending Entrangled by the attending father of the funeral director, page 2 should be detached for use as	-						
Box		iclai	Part II. Other algrificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.  23b. Did tobacco use contribute to the cause of death?					
Ision of Vital Records, P.O.		Physiclan/	Takin. Sine algumban conditions contributing to death but not result	ng in the underlying cause giv	enin rani.			Probably 4 Unknown
		Ď						
		Completed				24a. Was an perform		. Were autopsy findings available prior to completion of cause of death?
						1 ☐ Yes	2 No	1 ☐ Yes 2 ☐ No
		o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ F6	Oth	26. Place of Death (C			
		ition: To	Inpatient 2 El	8b. Time of Injury Wor	4 □ Nursing Home		v injury occurred	ecify)
Divis		Certification:	3 □ Suicido 6 □ Could not be	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and City or Town, State)			Rural Route Number,	
J		edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.					
_	0 000	Σ	29b. Signature and title of certifier	29c. Licens			d. Date signed (Mor	
			Hermiter Hoxacur		02321-149		JULY 1	0, 1997
	5		SO. Name and address of person who completed cause of death (Item 23a) (Type, Print) JENN IFER HAVERY MD					
SIMAL HOSPITAL OF BALLIMOZE 2401 WEST BELVEDERE AVENUE, BACIMUNE.  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature							end 2	215
	કાટ Registr		1 5 1997   1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					

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Item: 20b, per FState of Maryland / Department of Health and Mental Hygiene	97	2134	3

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Thomas Signature Thomas Signature State and number 1.00 Harbor 1.0	3. Time of Deeth
### Part   County of Deeth   C	2:56 PM
Social Security Number  1	2.50 111
Second Security Number   S. Sex   T. Age (in yrs. set birthold)   M. Morths   Days   Hours   Min.   12 - 14 - 42   S. Sex   Sex   S. Sex	
Usual Residence of December  100. State  100. Curry  100. State  100. State  100. Harborview Drive Apt. 2107  21230  100. Harborview Drive Apt. 2107  21230  100. Harborview Drive Apt. 2107  21230  100. Harborview Drive Apt. 2107  21230  100. Harborview Drive Apt. 2107  21230  100. Harborview Drive Apt. 2107  21230  100. Harborview Drive Apt. 2107  21230  100. Harborview Drive Apt. 2107  11. Mariel Status  12. New Expectation of The State of Wheth Count Writes, Specify Clubian, Mariedan, Pusario Rican, etc.)  12. New Expectation of The State of December States of December State	eca (Stete or Foreign
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Date of the property of the place of the pla	Code) 21230
20a. Method of Disposition    Date	to,Md.
Physician   Medical Examiner   M	
Physician   Medical Examiner   M	rgh, Pa.
Physician // Medical Examiner  Physician // Medical Examiner  Per part Enter the disease, or complications the traces of the death. Do not enter the mode of dying, such as cardiec or respiretory errest,    Immediate Cause (Final disease or condition resulting in death)	
Physician /Medical Examiner  Physician /Medical Examiner  Physician /Medical Examiner  Physician /Medical Examiner  Physician /Medical Examiner  Physician /Medical Examiner  Physician /Medical Examiner  Physician /Medical Examiner  Physician /Medical Examiner  Physician /Medical Examiner  Physician /Medical Examiner  Physician /Medical Examiner  Physician /Medical Examiner  Physician /Medical Examiner  Physician /Medical Examiner  Physician /Medical Examiner  Immediate Cause (Final disease or condition resulting in deeth)  Physician /Medical Examiner  Due to (or es e consequence of):  Due to (or es e consequence of):  Due to (or es e consequence of):  Due to (or es e consequence of):  Due to (or es e consequence of):  Due to (or es e consequence of):  Due to (or es e consequence of):  Due to (or es e consequence of):  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobecco use contribute to 1   Yes 2   No 3   Problem    Physician /Medical    Due to (or es e consequence of):  Due to (or es e consequence of):  1   Yes 2   No 3   Problem    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobecco use contribute to 1   Yes 2   No 3   Problem    This pect is a contribute to 1   Yes 2   No 3   Problem    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.  25b. Was case referred to medical exeminer?  25c. Place of Death (Check only one)	
Physician /Medical Examiner    Page   Physician / Medical Examiner   Page   Physician disease or condition resulting in deeth)   Page   Physician / Page   Physician disease or condition resulting in deeth)   Page   Physician / Physici	Approximete Intervel Between
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25. Was case referred to medical exeminer?	ilable prior to apletion of cause leeth?
25. Was case referred to medical exeminer?	Yes 25 No
exeminer?  Hospital: Other:	
Pospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	)
2 Accident investigation M 1 Yes 2 No	
4 Homicide determined determined determined determined building of the College Parameter (Street and number of Hurel Children to Hurel Chi	Route Number,
29a. Certifier (Check only one)  Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end pleca, end due to the ceuse(s) end manner es steel and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, D	ited. the cause(s)
Styph & Macly MD O.C. M.E. JULY 14,19	997
30. Name and address of person who completed cause of death (Ifem 23e) (Type, Print)	
State 31. Date filed (Month, Day, Year) Registrate Signeture	1201

State Registrar

DECKER Items: 23a part 1,27 per MED G-750 8/20/97 dn Certificate of Death    Decedent Name (First, Middle, Last)   Decedent Name (First, Middle, L		CARRI	E		State of Ma	ryland	/ Departmen	t of F	lealth and I	Mental Hy	/giene	37	21344
Carrie Becker    Victorial Committee   Carrie		BECKE	RI	ems:23a part I,27 per	MEO G-750 8/	20/97	dh Certificat	e of	Death		Reg. No.	•	
The control of the											eath	v.11	3. Time of Death
## Footby Name (Frost activation) go singer and number)  ## FORTIAL HOSP TITAL  ## FORTIAL				Carrie Becker									3 • 40D M
Second Secondary Number   1   28   3   5   5   5   5   5   5   5   5   5				4e. Fecility Name (If not institution, give	e street and number)		-,		4b. City, Town, or L				3 4 4 VF + M +
218—74—8054   10 miles of the control of the contro	L								HAVRE D	E GRAC	EHARF	ORD (	COUNTY
Discreption   Discreption							Months			8. Date of Bi (Month, D	rth a <i>y, Year)</i>	9. Birthple Count	ece (State or Foreign ry)
10s. State   10c. County   10s. Chy   10s.						35	113.			December	r 7, 1961	Mar	yland
Mr. Randall M. Becker / Husband  105 Glenville Road Churchville, Md. 21028-1103  20b. Method of Disposition  1 Method of		yland				10c. City,	Town or Location					10	d. Inside City Limits
Mr. Randall M. Becker / Husband  105 Glenville Road Churchville, Md. 21028-1103  20b. Method of Disposition  1 Method of		Mar a-f et	tor	Maryland Harfor	rd	Chi	urchville						1 ☐ Yes 2 No
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Mr. Randall M. Becker / Husband  105 Glenville Road Churchville, Md. 21028-1103  20b. Method of Disposition  1 Method of		tems Nor II	nue		Armed Forces?			dent ot F cify Cub	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)			
Mr. Randall M. Becker / Husband  105 Glenville Road Churchville, Md. 21028-1103  20b. Method of Disposition  1 Method of	Z	s eft		**	It Yes, Give	0	1 ☐ Yes	2 <b>⋈</b> No	Specify:		Specif	y:	10-14-
Mr. Randall M. Becker / Husband  105 Glenville Road Churchville, Md. 21028-1103  20b. Method of Disposition  1 Method of	5	2 hou					16a. Decedent's Usu	al Occur	nation		16b Kind of B		
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23a Part Letter the disease of complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest.  Approximate individe derives a consequence of	0	Dep Impo		Land Too	see Mark I.	Zavoy	Ruck	- T	owson Fur	neral H	ome. Inc		
Physician / Medical Examiner    Part   Department   Depar				23a. Part1. Enter the disease or min	plications that caused t	he death	1050	Yor	k Road	owson.	Marylan	d 21	
Madical Examiner    Mathematical Examiner   Mathematical Cause (Final disease or condition resulting in death)   Due to (or as a consequence of):		Physician		shock, or heart tailure. List only	one cause on each line	).	DO NOT GING! THE MO	or ayıı	ig, such as corolac	or respiratory i	arrost,	,	Interval Between
Due to (or as a consequence of):    Due to (or as a consequence of):		/Medical		Immediate Cause (Final	DICUT VE	NTDICH	AD DVCDI ACT	A 05	THE HEADT				
Due to (or as a consequence of):    Due to (or as a consequence of):		Examiner			-				THE HEART				
Cause (Disease or Influence of	٠	P #	iner	_		,						-	
Cause (Disease or Influence of		and I-trans	хаш	Sequentially list conditions,	D	ue to (or a	s a consequence of):						
Due to (or as e consequence of):  d.    Due to (or as e consequence of):	Š	be ex		Cause (Disease or Injury	C							1	
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25. Was cese refarred to medicel examiner?    26. Place of Death   Check only one    27. Manner of Death   XX Natural 2   Accident 3   Suicide 4   Homicide   Bettermined   28a. Data of Injury   28b. Time of Injury   28b.	ט	lew r	nple									of d	aath?
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who complated cause of death (Item 23a) (Type, Print)	ģ-	dint	Sert	4   Homicide	building, etc.	(Spacify)				City or To	wn, Stata)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		ospita hours uners ly fille			sician: To the best of	my knowle	dge, daath occurred	at the tir	ne, data and place,	and dua to the	causa(s) and ma	annar as sta	itad.
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30. Name and addrass ot person who complated causa ot death (Item 23a) (Type, Print)		To To To To To To To To To To To To To T	2	29b. Signature and title of certifier	00 1/3		29	c. Licens	e number		29d. Date signe	d (Month, E	lay, Year)
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I LIMING WITH A KINGTON FWI III PANN STRAT RAITIMARA Margland 21201						ath (Item 23		_ ~	-				- 3 01000
State 31. Date tiled (Month, Day, Year) 32. Registrar's Signature				14120112 D-1601	will will		TIT Leui	$n_S$	reet, E	saltım	ore, Ma	aryla	na 21201

State Registrar



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Physicia				Ce	illioat	e of i	Jealli		Reg. I	lo.		
/Medic		1. Decedent's Nama (First, Middle, Last  Denzil D. B	olyard					2. Date	of Deeth		Yeer 197	3. Time of De
Examin	_	4a. Facility Name (If not institution, give	ospita/	900 CA	FTON AVEN	ie i	./	MORE	Death	c. County o	f Death	
Funeral Director		234 34-2207	7. Age (In ØM 2□ F	yrs. last birthday, Yrs.	If Under Months	1 Year Deys	If Under 24 Hours	Min. 8. Dete Mon May	of Birth th, Day, Yes 22, 1	34 W	9. Birthpla Countr	ice (State or Fi
show	J.	Usual Residence of Decedent  10a. State 10b. County  Maruland Baltimo		c. City, Town or L			11.00				10	d. Inside City t
ith the Maryle or 28a-f shore	Funeral Director	Maryland Baltimo  10e. Street and Number	re		10f. Zip		Hall		10g. (	Citizen of What Country?		
238	<u>a</u>	4218 Piney Park	Road			2112	8		u	.S.A.		
/2 nours ener death with the marylend natural', or items 23a or 28a-f show incal Examiner mast be nutified at	by	11. Marital Status  1 □ Never Married 2 🛣 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	in U,S. 13.	Wes Deced If Yes, spec		ispenic Origi n, Mexicen, i Specify:	n? (Specify Yes Puerto Rican, et	or No- c.)		- America , White, et	
e • 🗸	To Be Completed	15. Decedent's Edu (Specify only highest grad	cetion le completed) College (1-4or 5+)				ation during most o	of working		Kind of Bus		
filed wi Hygien ther th	5	8th grade		N	lachin	ust				anufa		ng
should be filed ad Mentel Hygis marked other imatic event, II	To Be	17. Father's Name (First, Middle, Last)  Payton Bolya	rd				18. Mother's	s Name (First, N La	fiddle, Maid Fike		)	
1 end 2 should Health and Men em 27 is marke ther treumatic		19a. Informant's Name/Relationship (7)  Lora J. Bolyard	(pe, Print) (wife)		-			or Rural Route I			Stata, Zip ( 211	
ant of t: If it y or o		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	Removel from State	Ob. Place of Disponentery, cre Oak Lau	metory or o	ther plac	,	7/16/		Location - C		m, State Iarylan
Departme importan any injur once.		21. Signature of Funeral Servica Licens	9	2	Schi	MUNQ	ss of Facility	eral Hon	ies, I	nc.		
	-	23a. Pert1. Enter the disease, or complishock, or haart failure. List only o	u					i., Bali		, MU	2123	Approximate Interval Betwee
ding physician and se as the burial-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Entar Underlying Causa (Disase or injury that initiated events resulting in death) Last	c	to (or as a consecto (or as e consec								
atten for u		Part II. Other significant conditions con	d.	t resulting in the I	anderlying o	vin esua	en In Part I	23h	Did tobac	co use conf	ribute to	the cause of c
8 6	y Physician			t recounting in the					1 Tes			ably 4□Un
0 0 0	d by							249	. Was an au	topsy	24b. Wer	e autopsy find lable prior to
been sign should be	plete								performad		com	pletion of ceus eath?
has been ge 2 shool	Complete		-					240	performad	2 1 No	of de	eath?  Yes 2 No
has been ge 2 shoul	Be Completed	25. Was case rafarrad to medical						of Death (Check	performad		of de	eath?
his cardicate has been il director, page 2 shoul	To Be	examiner?  1  Yes 2 No  27. Mannar Daath  1  Natural 5 Pending	Hospital: 1 ☐ Inpatient  28a. Data of Injury (Month, Day Yea	2 DER/Outpatia 28b. Time of Injury	of 2	8c. Injur	ar: 4□ Nurs y at k?	of Death (Checking Home 5 28d. Des	performad*  1 ☐ Yes  only one)  Residance	2 15 No	com of de 1 □	eath? Yes 2□ No
After this certificate has been funeral director, page 2 should	To Be	examiner? 1 Pres 2 No  27. Mannar Daath	1 L Inpatient	28b. Time of Injury  At home, farm, st	M 2	8c. Injury Work	ar: 4□ Nurs	of Death (Check ing Home 5 [ 28d. Des	performad'  1 ☐ Yes  only one)  Residance cribe how in	2 □No  6 □Other jury occurre and Numbe	com of did	eath? Yes 2□ No
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 950DOR5 10 /Medical Name (If not institution, give street end number)

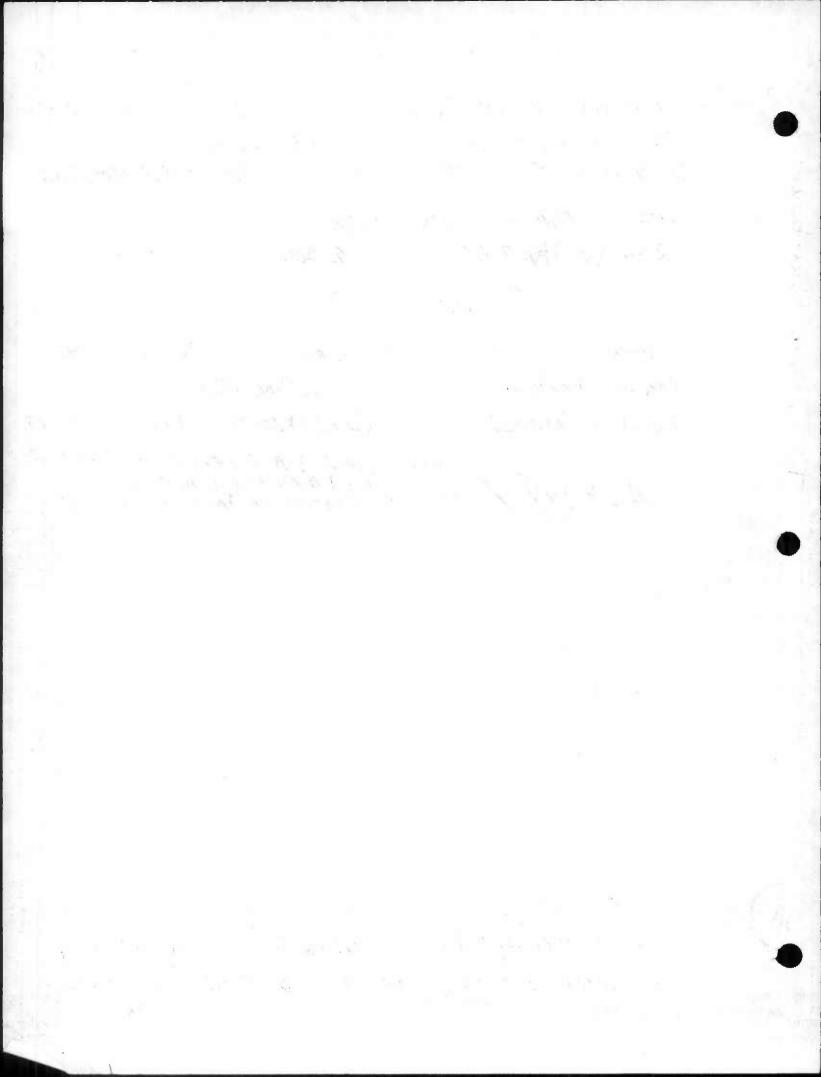
NOSCOUR HOSPITAL 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7 Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign **Funeral** 19M 20 F Months Days Hours 13ar bour Yrs. **Director** Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 Yes 2 No by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates: WW ☐ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 1 Never Married 2 Married 1□ Yes 2⊡ No 3 Widowed 4 Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry eodora condary (0-12) College (1-4or 5+) TECHNICIAN 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DOWARD Informent's Name/Relationship (Type, Print) or other altimore, 20b. Place of Disposition (Name of cemetery, crematory or other placa, 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State Other (Specify) any injury 4 Donation 21. Signature of El neral Servica Licenses by complications that caused the death. Do not enter the mode of dying, such as cardiac or ree. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final disease or condition resulting in death) **Examiner** ettending physician end for use es the buriel-transit or Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 N Unknown 1 Yes 2 No þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? certificate has 2 X No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No Medical Certification: To After this In by the funeral 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending Investigation 1 Matural 1 ☐ Yes 2 ☐ No death 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Mer 4 Homlcide 12 Certifying Phyelclen: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) D27860

State Registrar 31. Date filed (Month, Pay, Yeer)

Julias Davidanas Mandala

700 WASH, BIND BALT MD

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth JULY 12 Dey 199 Year **Physician** Marguerite Regina Borchers 7:40 am /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 5 Overbrook Road Catonsville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys 1□ M 2➡F 216-28-5518 Yrs. 95 Director SEP 18, 1901 Maryland Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f showing Medical Examinar regard be notified at MD Baltimore Catonsville 1 ☐ Yes 🌪 🗆 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5 Overlook Road 21228-1945 daath y Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Raca - American Indien, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) permit. Pagas 1 and 2 should be filed within 72 hours after to Department of Haelth and Mental Hygiena. Important: If Item 271s marked other than "near any Injury or other terms." 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 □ Divorced Specify: White Completed 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Construction Secretary Business 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) George Ernest Straub Emma Doenges 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) LeRoy B. Mathews/son 128 Dunkirk Rd. Baltimore, MD 21212-1750

20b. Pleca of Disposition (Name of cametery, cremetory or other piece)

20c. Location - City or Town, Stete 20a. Method of Disposition

Method of Disposition

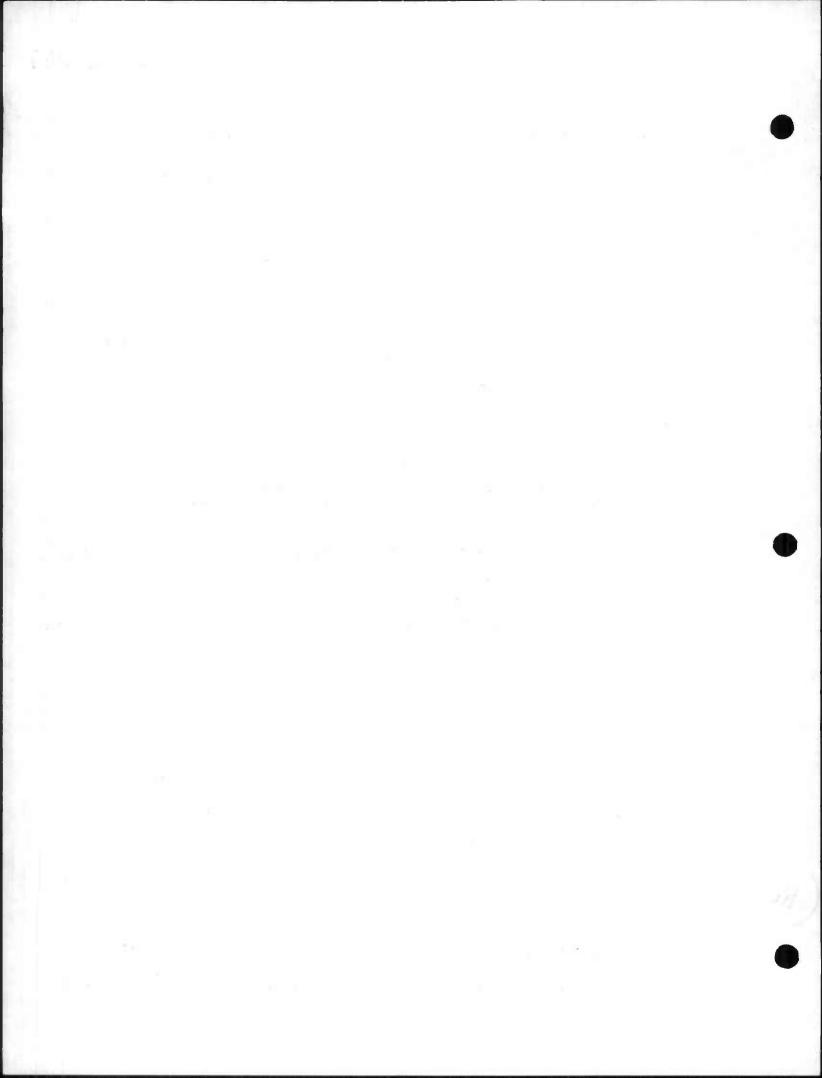
□ Disposition

□ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Western Cemetery 7/15/97 Baltimore, MD 22. Name end Address of Facility
MacNabb Funeral Home, P.A. of Funeral Service License Dawn F. McDonald 301 Frederick Rd. Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting in death) Examiner Examiner Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Lest Bnd physiolan Physician/Medicai the state Due to (or es e consequenca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. a pe 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 1 ☐ Yes 2 ☐ No certifica 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yes 2 No 0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA g 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1. Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homloide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and placa, end due to the ceuse(s) end manner stated. 2 To the Within 2 To the 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 14 popler coposice Lorre 5306 Borrono Muy CHARLES R. GRANGEN OR 31. Dete filed (Month, Day, Year)

Registrar

State istrar JUL 1 5 1997

22. Registrer's Signature July Davidson—Rendelle



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BALTIMORE, MARYLAND 21215-0020

RECORDS, P.O. BOX 68760

DIVISION OF VITAL

OR ATTENDING PHYSICIAN

this certificate nith the State

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DIRECTOR: A

TO THE HOSPITAL
TO THE FUNERAL (
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IMPORTANT: If it HOSPITAL

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31. DATE FILEO (Month, Day, Year) JUL 1 5 1997

Pages 1, 2, 3 should

97 21348 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH GBROWN IAM 11:20 am 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 705-05-2419 1 M 2 F DAYS HOURS 2-17unknown 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Caton Manor Baltimore Baltimore City RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Baltimore City Baltimore City 1 TY YES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 2434 Christian Street 21223 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerlo Rican, etc.) IF YES, GIVE WAR OR DATES unknown 1 TYES 2 THE NO Specify: Specify: White BY 3 Widowed 4 Divorced COMPLETED 15. DECEOENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) unknown unknown unknown unknown 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) unknown unknown BE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number City or Town, State, Zin Code) 0 Hanna Brown/wife 2434 Christian Street, Baltimore, Maryland 21223 20a. METHOD OF DISPOSITION
1 Burlel 2 Cremation 3 Removal from State 20h. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State 4 Donetton 5 Ther (Specify) in state Ronald S. 21. BIGNATURE OF FUN 22. NAME AND AODRESS OF FACILITY Director Wade State Anatomy Board, 655 W. Baltimore St. Baltimore, Maryland 21201 Mide I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or haart failura. List Dnly ona cause on each lina. interval Between Onset and Death IMMEDIATE CAUSE (Fine) disease or condition ougetune alesle resulting in death) DUE TO (OR AS A CONSEQUENCE OF) Elow 40% CERTIFICATION Sequentially list conditions, DUE TO (OR AS A COMSEQUE Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART il. Other significant conditions contributing to deeth but not reaulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATH (Check only one) EXAMINER? OTHER:
4 Nursing Home 5 Realdence 8 Other (Specify) HOSPITAL 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 5 Pending Investigation 10 Natural 1 YES 2 NO BY 2 Accident 3 Sulcide 28a. PLACE OF INJURY — At home, farm, atreet, factory, offica building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) end manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Vyuse M) Hellending Doda 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C.V. CYRIAC. M-D 8109 RITCHER ans

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.

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State of Maryland / Department of Health and Mental Hygiene 97 2131.0

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Yeer ANITA CULCTTA 11, 1997 JULY /Medical 1:27PM 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** THE JOHNS HOPKINS HOSPITAL N/A BALTIMORE E
8. Date of Birth
(Month, Dey, Year)
AILQ. 17, 1920 If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthpiace (State or Foreign Country) **Funeral** 1 □ M 2 K F Days 216-09-1836 76 Yrs. Director Usual Residence of Decedent deeth with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at Maryland Baltimore Lutherville 1 ☐ Yes 2 No Director 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country? 1309 Broadway Road 21093 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Raca - American Indien, Biack, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiane. Important: If item 27 is merked other than "natural". As any injury or other traumate. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: White. by 3 Nidowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondary (0-12) 7th grade Own Home Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Canzani Rose Perruggini 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Vincent A. Culotta (son) 1309 Broadway Road, Lutherville, MD 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Remove from State Most Holy Redeemer Cem. 7/15/97 Baltimore. Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nome and Address of Facility
Schimunek Funeral Homes, Inc. 21. Signeture of Funerel Service Licansee 9705 Belair Rd., Baltimore, MD 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervet Between Onset end Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical 2.5 YEARS COROLARY ARTERY DISEASE Examiner Due to (or es e consequence of): Examiner thet the death certificate be axecuted the burial-trensit Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest end Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of): USB BS been signed by the e should be datached f Pert II. Other eignificent conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24a. Wes en eutopsy performed? 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? Completed 1 Yes 2 No 1 ☐ Yes 2 No After this cartificate To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this cartifice Be 25. Was cese referred to medical 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? Medical Certification; 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Text Certifying Physicien: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and manner steted. 29a. Certifier pletaly 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) all LE MO RES-000 11, 1997 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) ENGL HATEK M.D. N. WOLFE STREET, BALTEMORE MARTLWID 600 32. Registrer's Signature State ie savidson-Randelle

**DHMH 16 Rev 6/95** 

State of Maryland / Department of Health and Mental Hygiene 0.7

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į.	Examir		4e. Fecility Nama (If not institution, giva				4b. City, Town, or I	Location of Daath	4c. County	of Death		
			GREATER BALTIMO				TOWSON		BALT			
	Funeral Director		5. Social Security Numbar 6. Sa: 215-44-1710	7. Aga (In yi	s. last birthday, Yrs.	Months Day		8. Data of Birth (Month, Day 02-21-	Yeer) -1905	Yeer) 9. Birthplaca (State or Foraign Country) MARYLAND		
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ij	Pages ment of ant: If Ite ury or o		1 Burial 2 □ Cramation 3 □ R 4 □ Donation 5 □ Othar (Spacify)				DEEMERO7	/16/97	BALTO	.,MD.		
Baltimore,	permit. Pages Department of Important: If I any Injury or once.		21. Signatura of Funaral Service Licanse	na /		2. Nama and Add	,					
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Box	death	iciai	Pert II. Other eignificant conditions con	tributing to death but not re	eulting in the u	indertuing course o	siven in Port	23b Did to	bacco uso co	narihusa so sa	e cause of death?	
P.O.	thet the death cert ed by the attendin deteched for use	Physician/N	Total Outer eignineant conditions con	mouning to death out not re	asutting in that u	manying ceuse g	ovan in Parti.		es 2 No		bly 4 Unknown	
	S 5 8	by F										
Records,	v requires thet the been signed by th should be deteche	ted						24a. Was a perform	n autopsy ned?	evaila	autopsy findings bla prior to	
ec	aw as b	Completed								comp of das	lation of ceusa hth?	
	The ete h page	Con						1 □ Y	es 2 16	10Y	es 2 No	
Vital	Physicien: The ribis certificete	Be	25. Was case referred to medical examiner?	ospital			7	th (Check only on	e)			
ot	두 후 교	- To	1 Yes 20 No	1 Minpatient 21	ER/Outpatier	III SELDON		ome 5 Reside		71.0		
	ding h. After fune	Certification:	1 (Natural 5 ☐ Pending	28s. Date of Injury (Month, Day Year)	28b. Time o Injury	W	ork? ⊇Yes 2⊡No	28d. Describe h	ow injury docum	ed		
Division	Attending or death.  • ctor: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be	28s. Place of Injury - At	home, farm, str			28f. Location (St	reet and Numb	er or Rural R	oute Number,	
Ö	al or A s efter il Direct	Cent	4 ☐ Homicide determined	building, efc. (Spec			City or Town	n, State)				
	ospit hour uners	edical (	29a. Certifier 1 Cartifying Physical Examination	Iclan: To the best of my kr er: On tha basis of axadir	nowladge, daet	h occurred et the	tima, data and place	, end due to the c	ause(s) end me	nnar as state	ed.	
	To the Hospital or Attending I within 24 hours efter death.  To the Funeral Director: After completely filled in by the fune.	Medi	one)	and mennar states.								
	P P P	=	29b. Signatura and the of contribut	1	/ 11	29c. Licer	nsa number	0.	9d. Data sign	a (Month, ga)	y, Yaar)	
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17	/		30. Nama and odd ess of person who co ALAN SHOROFSK				TTE MOTE	COM MD	2120	1		
Í	Sta	te	31. Data filad (Month, Day, Yaar)	which The distrar's A		FIOUNT F	AVE. TOW	SON, MD.	2120	1 •		
			1111 1 5 1007 3	THE PERSON NAMED IN THE PERSON NAMED IN	. P. And							

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death **Physician** Month 12, 12:40 AM GLADYS COLBY JULY 1997 /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Towson Baltimore Saint Joseph Medical Center 8. Date of Birth (Month, Pay, Yeer) Dec 14, 1908 If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (Stete or Foreign **Funeral** Months Deys 1 M 3 F 88 Yrs. Maryland Director 214-01-9053 Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Maryland N/A Baltimore 1 X Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2725 Hampden Avenue 21211 U.S.A permit. Pages 1 and 2 should be filed within 72 hours efter deeth Depertment of Health and Mentel Hygiene. Important: If Hem 27 is marked other than "natural", or Itama 23 eny Injury or other traumatic event, The Medical Examination and pays in the Medical Examination. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: White 3 X Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) unk College (1-4or 5+) Fabric Cutter Grief Clothing Co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ashby Powell Jessie Milton 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Jack S. Taylor (Son) 2725 Hampden Avenue, Baltimore, Maryland 21211 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from State 7/16/97 Green Mount Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Maryland 21211 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heer failure. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel SEPSIS diseese or condition resulting in death) Examiner Due to (or es e consequence of) Examiner ENDOCARDITIS bunel-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest pue Due to (or es e consequence of): Box 68760 physician Physician/Medical the Due to (or es e consequence of) 80 esn fo ed by the e Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CHRONIC ATRIAL FIBRILLATION þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en autopsy performed? Completed peen s CHRONIC OBSTRUCTIVE LUNG DISEASE hes 1 🗆 Yes 20 No 1 ☐ Yes 2 🛛 No this certificate Division of Vital nding Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No funeral director, Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 TV Inpatient 2□ ER/Outpetient 3□ DOA 28a. Date of Injury (Month, Day Yeer) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Ather 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Phyelden: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

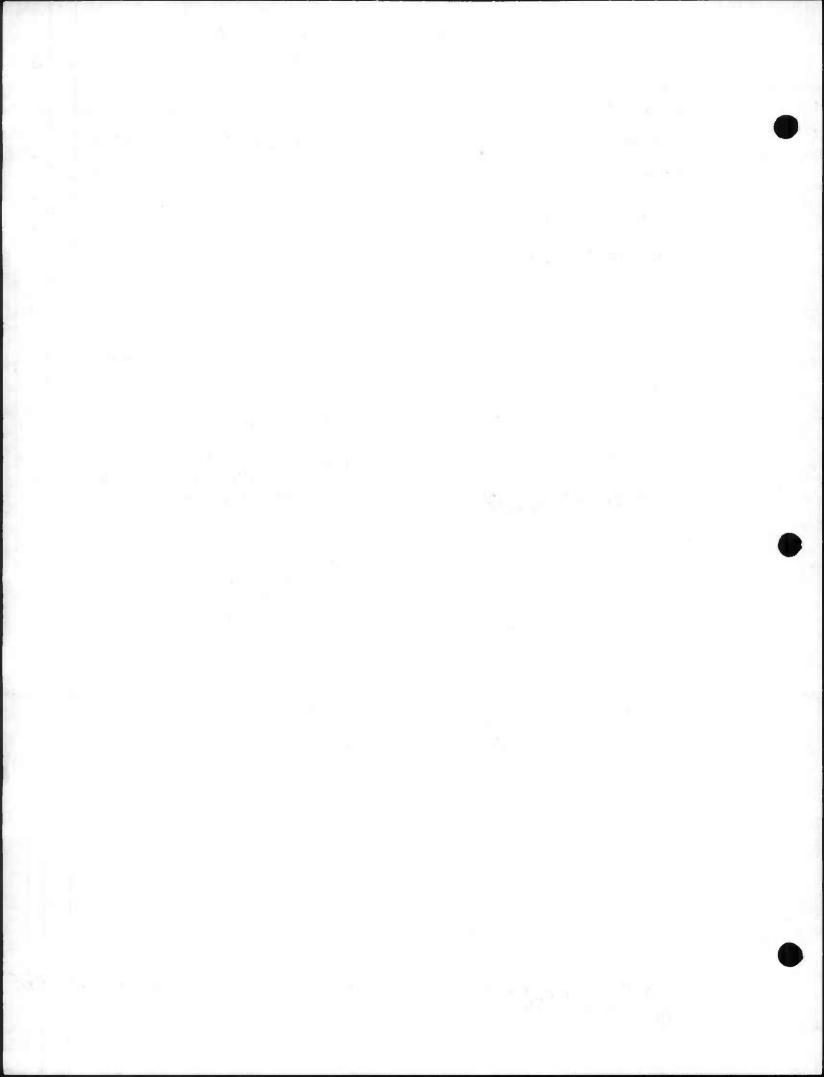
| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number D37254 -12-97 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) M. D., 7620 YORK ROAD, TOWSON, MARYLAND 21204 BOON P. LIM. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State wha Davidson-Randall Registrar JUL 1 5 1997

**DHMH 16 Rev 6/95** 

State of Maryland / Department of Health and Mental Hygiene Q 7

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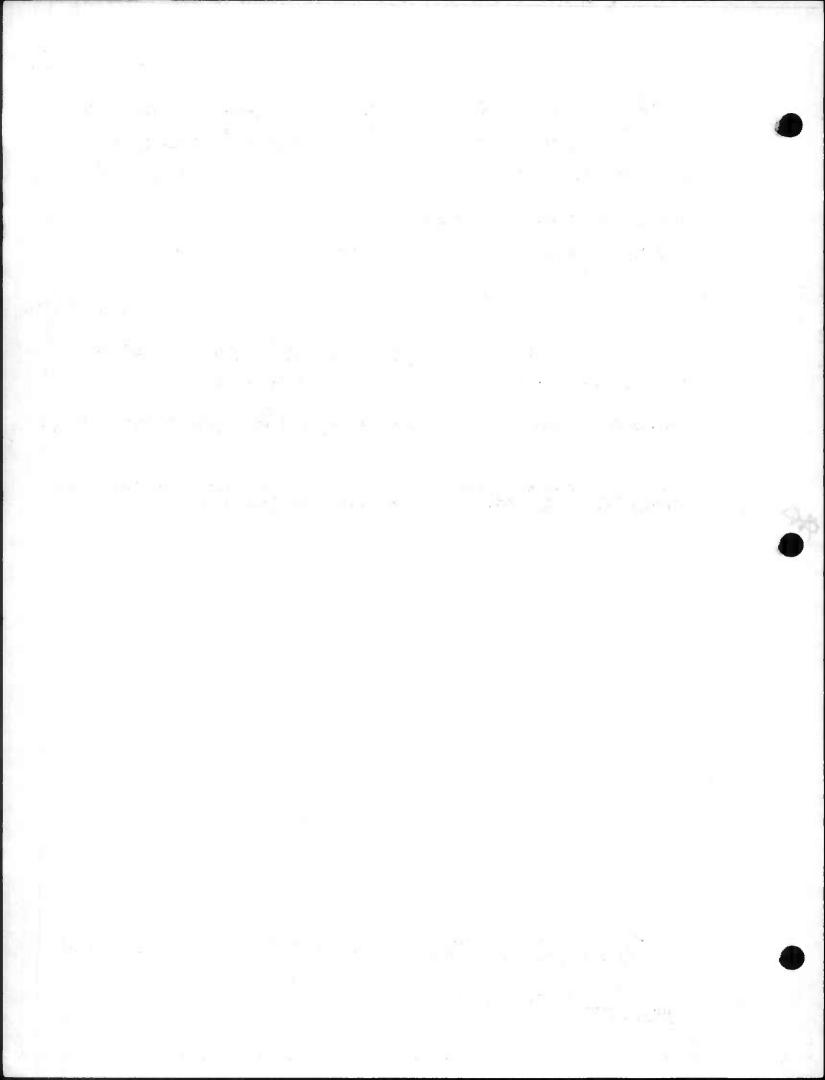
					Ce	rtificate o	f Death			Reg. No.	21	21000	
	11, 14		1. Decedent's Name (First, Middle, La	st)					2. Dete of Dec	eth		3. Time of Deeth	
	Physici		FRANKLIN DON	ALD COOLEY					Month July	10	1997	12:02 AM	
	/Medic Examir		4e. Facility Neme (If not institution, giv	e street end number)			4b. City, To	own, or Lo	cation of Deeth		unty of Deeth	10.00 111	
	EAUITIII		Suburban Hospita	1			Bet1	hesda	a	Mor	ntgomer	-v	
	Funeral		5. Sociel Security Number 6. S	ex 7. Age	(In yrs. last birthday		ar If Undar	24 Hrs.	8. Date of Birt (Month, De)	. 1		2	
	Director		577-24-5752  Usual Residence of Decedent	DKM 2□F	7.3 Yrs.	Months Dey	ys Hours	Min.	(Month, De) August	y, Yeer) 13,192	23 Mi	placa (State or Foraign ntry) SSOUTI	
	A su		10a. State 10b. County		10c. City, Town or L	ocation					1	Od. Inside City Limits	
	in 72 hours after death with the Merylend I "natural", or Items 23s or 28s-f show fed cal Examiner must be notified at	Funeral Director	Virginia Fairf	ax	Centrevi	lle						1 ☐ Yes 2 🛣 No	
	it of	ā	10e. Street end Number			10f. Zip Code	9			10g. Citizan of Whet Country?			
	23a	ā	6525 Creek Run D	rive		20121				USA			
	or de	une	11. Marital Stetus	12. Was Decedent Ex Armed Forcas?	ver in U,S. 13.	Wes Decedent of If Yes, specify C	of Hispanic Ori uben, Mexicar	igin? (Spen, Puerto	ecify Yas or No- Rican, etc.)	- 14.	Race - Amaric Black, White,		
21215-0020	ours afte	þ	1 ☐ Naver Married Ž Marriad 3 ☐ Widowed 4 ☐ Divorced	1 □Wes 2 □ No If Yes, Give Yeer or Datas:1 9		1□Yas 2XIN					pecify: Whi		
9	2 ho	Completed	15. Decedent's Ed	ucetion	16e. Dece	dent's Usual Occ	cupetion		G. C.	16b. Kind	of Business/In		
216	C 1 0	pie	(Specify only highest gra	de completed) College (1-4or 5+	life	e kind of work do DO NOT use ret	na dunng mos ired)	it of works	ng				
21	be filed within ital Hygiene. Id other then "	Om	Clothoritally/Socoridally (0-12)	3		ner				Carpe	et Reta	il	
P	al Hygid other	Be C	17. Fether's Neme (First, Middle, Last)				18. Mothe	er's Name	(First, Middla,				
<u>a</u>		TOE	Franklin Bixby C	ooley			Ivy	Lapt	tad				
Maryland			19e. Informant's Name/Relationship (	Type, Print)	19b. Mail	ing Address (Stre	-			er, City or To	own, Stata, Zip	Code)	
	カチトラ		Shirley O. Coole	y / Wife	6525	Creek R	un Dr.	,Cent	treville	e, Va.	. 20121		
J.	工工员员		20a. Method of Disposition		20b. Place of Disp	osition (Name of			Date		ion - City or To		
9	Peges nent of nt: If Its iry or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Metropolitan Crematory 7/11/97 Alexandria,										
Baltimore,	artme ortan Injur		21. Signature of Funeral Service Licer	<u> </u>								va. UNERAL HOM	
Ba	permit. Peges Department of Important: If It any Injury or once.		I fety of	P. Hole					Ave.,				
			23e. Part1. Entar the disease, or com shock, or heert failure. List only	olications that caused t	he death. Do not en	iter the mode of o	lying, such as	cardiac c	or respiretory er	rrest,	10	Approximate	
	Physician		Shock, of fieed failure. List only	one cause on each line		An .					i	Intervel Batween Onset and Deeth	
	/Medical		Immediete Ceuse (Final	Carl	ens	DOVA	thin	116					
	Examiner		disease or condition resulting in deeth)	е.	Oue to (or es e conse	104 8 0	/ PL PP	· ·					
		je l		A and		W CAL	lial	K	ngain	from			
	certificete be executed rding physician end use es the buriel-transit	Examiner	Sequentially list conditions	b. D	ue to (or as a coase		wy	/	1000	,	lista		
ó	an er riel-t		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events	Affler	ode/	ter a	Ina	Lu	arte	W a	lista	A	
68760,	ite be ysici	cal	Ceuse (Disease or Injury that initieted events	c. J	ue to (or as a conse	guence of):	. ,	-)		1			
99	entifice ding ph	Medical	resulting in deeth) Lest					/					
Box	n cer endir use	2	•	d				-(-			_		
<u>.</u>	thet the death ce ned by the ettendi deteched for use	Physician/	Pert II. Other significant conditions of	ontributing to death but	not resulting in the	indedvina ceuse	given in Pert I		23h Did t	lobacco use	e contribute to	the cause of death?	
Ö	by the	hys	CAIT	+	10	/ /	1	-		Yes 2 l			
σ,	thet ned b	by P	STAN- DO	1 wegi	in the	10cu	ruce	_	, ,	108 201	NO 30110	Daby 42 Olikilowii	
Vital Records,	requires that been signed be hould be dete		Smourana	1.11.	to ,	1 8.	64		24a. Was	an autopsy	24b. W	ere autopsy findings	
8	> 11 0	ete	10 00000	seff t	2000	C, Pag	3		perfo	rmed?	CO	eilable prior to mplation of causa	
Re	e law hes b ge 2 s	Completed	common ile	2 -1	2-1.	,				- 44		death?	
a	Ician: The l certificate he rector, page		0 11 11 000	i c and	vie,				1 U Y	∕as 2ŪN	10 1	☐ Yes 2☐ No	
₹	Physician: this certificated director,	Be	25. Wes case referred to medical exeminer?	Hospital:				of Death	(Check only o	ne)			
o	Physi this rel dir	2	1 ☐ Yes 2 ☐ No	1 La Inpatient		III SLI DOA			me 5 Resid			(y)	
Ē	h. After funer	Certification:	27. Manner of Deeth  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Yeer) 28b. Time of Injury	V			28d. Describe h	now injury o	ccurred		
sic	Attending ir deeth. actor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be			M 1	☐Yes 2☐						
Division	or Attendent efter deet Director: In by the		4 Homicide determined	28e. Plece of Injury building, etc.	y - At home, farm, st <i>(Specify)</i>	reet, factory, offic	00	1	28f. Location (S City or Tow	Street end N vn, State)	lumber or Rure	al Route Number,	
	pspital of hours elumeral Dine		~										
	To the Hospital or Attending I within 24 hours effer deeth. In the Funeral Director: Affer completely filled in by the fune	edical	29a. Certifier (Check only one)   Certifying Ph 2  Medical Exam	rsicien: To the best of iner: On the basis of e and menner state	xaminetion end/or in	h occurred et the westigetion, in m	time, date an y opinion, dee	id plece, e ith occurre	end due to the o	cause(s) and date and pla	d menner as s aca, and due to	teted. the ceuse(s)	
	To the transfer of the transfe	Ž	29b. Signature and titla of certifier	11		29c. Lice	ense number			29d. Date si	ignad (Month,	Dey, Year)	
N	4		1/ Vicenti	. Ly	ma	hos	302	5			7-10	-97	
	116		30. Name end eddress of person who	completed cause of dec	eth (Item 23e) (Type	, Print)			. 1	_ ,	-	-	
-	1		VINCENTE de 1	TUAMA	W 1071.	5 FEPK	/Wood	1R	1. 574.5	04 8	ETHER	DAMOZA	
	Sta	te	31. Deta filed (Month, Day, Year)	A. S. Pagstrac	s Phantelle	·		-10	U				
	Registr	ar	JUL 1 5 1997			•							



State of Maryland / Department of Health and Mental Hygiene

97 21354

				C	Certificate of	Death		Reg. No.	1007
	Dhyoie	ian	Decedent's Name (First, Middle, Last)	0	. )		2. Dete of De Month	ath	3. Time of Death
	Physic /Medi		Hdeline (	ASS	104		June	29 199	97 5:00 PM
į	Exami		4a. Facility Name (If not institution, give street end number)	2 -		4b. City, Town, or Le	ocation of Deeth	4c. County of Baltin	
	Funeral Director		5. Sociel Security Number 6. Sex 1 M 2 F 7. As Usual Residence of Decedent	ge (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Bird (Month, Da	1 4900	9. Birthplace (Stete or Foreign County)
	with the Maryland a or 28a-f show be notified at	ctor	10e. State 10b. County Maryland Baltimore	10c. City, Town o	r Location				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	三 2 五	ral Director	10e. Street end Number 615 Chestnut Avenue		10f. Zip Code 21204			10g. Citizen of W	
0000	raff, or itame	by Funeral	11. Marital Stetus  1 Never Merried 2 Married  3 Widowed 4 Divorced  12. Was Decedent Armed Forces 1 1 Yes 2 He ff Yes, Give Year or Detes:	Ever in U,S.	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☐ No		ecify Yes or No Rican, etc.)	14. Race Black Specify:	- American Indien, s, White, etc.
5	72 h 'natu	etec	15. Decedent's Education (Specify only highest grede completed)	(6	ecedent's Usuel Occupative kind of work done	during most of work	ing	16b. Kind of Bus	iness/Industry
21215-0020	od within giene. er than	Completed	Elementary/Secondery (0-12) College (1-4or 4	- Iii	te. DO NOT use retire	tote Te	acher	5	School
Maryland	ould be file Mental Hy serked offs selfic event	To Be	17. Fether's Name (First, Middle, Last) The Rev. Samuel Barber			18. Mother's Neme Ellen I		Maiden Sumeme	)
Man	S and and and and and and and and and and	-	19a. Informent's Name/Relationship (Type, Print) Martin Cassidy/son		leiling Address (Street Narrows Cou				
Baltimore	Pages 1 and vent of Health nt: If item 27 rry or other to		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☒ Donation 5 ☐ Other (Specify)	aamalan.	isposition (Neme of cremetory or other pla	ce)	Date	20c. Location - 0	City or Town, Stete
Balti	permit. Page Department of Important if any injury or once.		21. Signature of Fu eral Servica Licensee, Romand S. Wa	de		ess of Fecility atomy Boar			imore Street
	Physician /Medical Examiner		23a. Fart1. Enter the disease, or complications that cause book, or heart failure. List only one ceuse on each limmediate Cause (Finel disease or condition resulting in death)	ne.	stroi		or respiratory a	rest,	Approximate Interval Between Onset end Death
0x 68760,	the death cartificate be executed y the attanding physician and iched for use as the burial-transit	/Medical Examiner	Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	Due to (or as a con					
D. Bo	e death the atter	Physician/	Part II. Other significant conditions contributing to death b	ut not resulting in th	ne underlying cause gi	ven in Part I.	23b. Did	tobacco uae cont	tribute to the cause of death?
s, P.O	A 48	by Phy	Chronic obsi	Locti	ne Lun	g disens	e 10	Yes 2□ No	3 Frobably 4 ☐ Unknow
of Vital Records,		Completed					24e. Was perfo	en eutopsy rmed?	24b. Were eutopsy findings evailable prior to completion of cause of death?
E E	sician: Tha law certificate has lirector, page 2	Cem					101	res 2000	1 Yes 2 No
Vita	clan: ertific ector,	Be	25. Was case referred to medical examiner?			26. Plece of Deat	h (Check only o	ne)	
on of	this alo	tion: To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatial  27. Manner of Deeth 1	y Year) 28b. Tim Inju	e of 28c. Inju			denca 8 DOther	
Division	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After complately filled in by the funer	Certification:	2 Cuiside 6 Could not be		, street, factory, office		28f. Location (S City or Tov		r or Rural Route Number,
	To the Hospital of within 24 hours at To the Funeral D completaly filled it	edical C	29e. Certifier (Check only one)  Certifying Physician: To the best 2 Medical Examiner: On the basis of and menner street.	examination and/o	eeth occurred et the ti r Investigation, in my o	me, date and pleca, opinion, death occurr	end due to the red at the time,	cause(s) end men date and placa, ei	ner es steted. nd due to the cause(s)
	To the To the comp	M	29b. Signature end title of certific	ley. v	29c. Licens 0 02	5205		T	(Month, Dey, Year) 30,1997
_			30. Name and address of person who completed gause of d	eeth (mg/l 23a) (Ty	pe, Print) havles St.	Balto.	md 2	120%	
	Sta Registi		31. Date filed (Month, Day, Year)  JUL 1 5 1997	yesifondell					

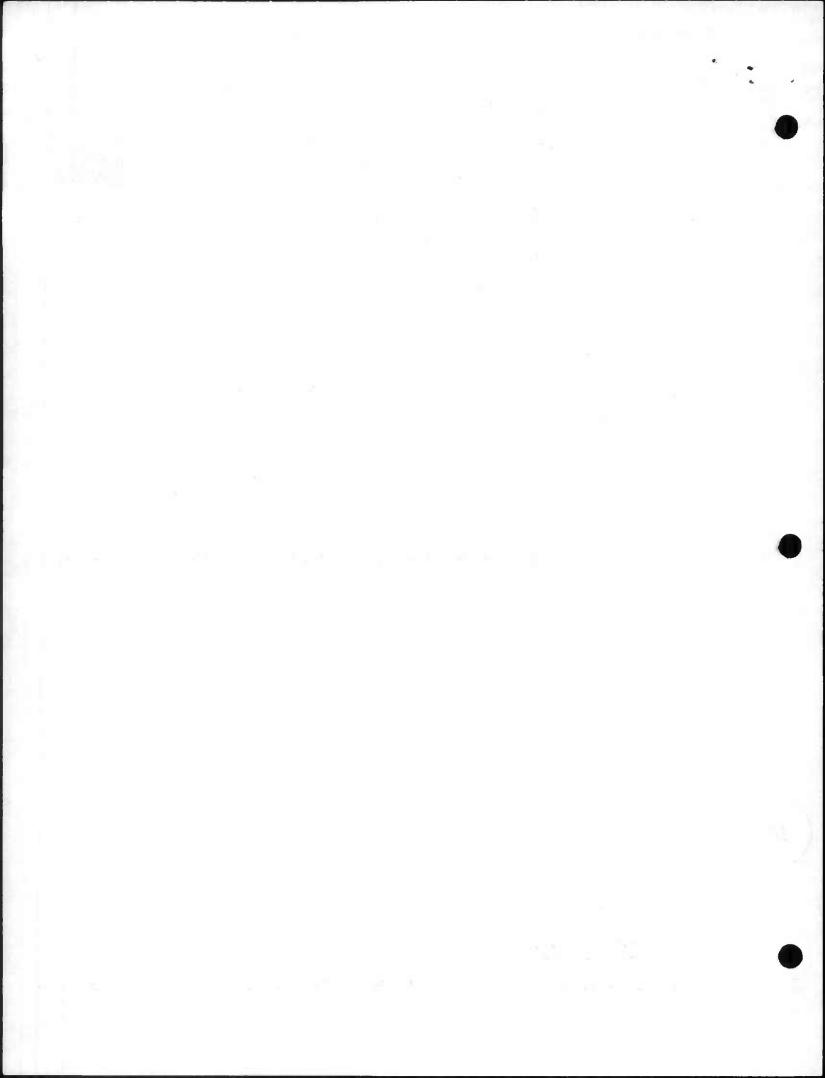


97-3739-510

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

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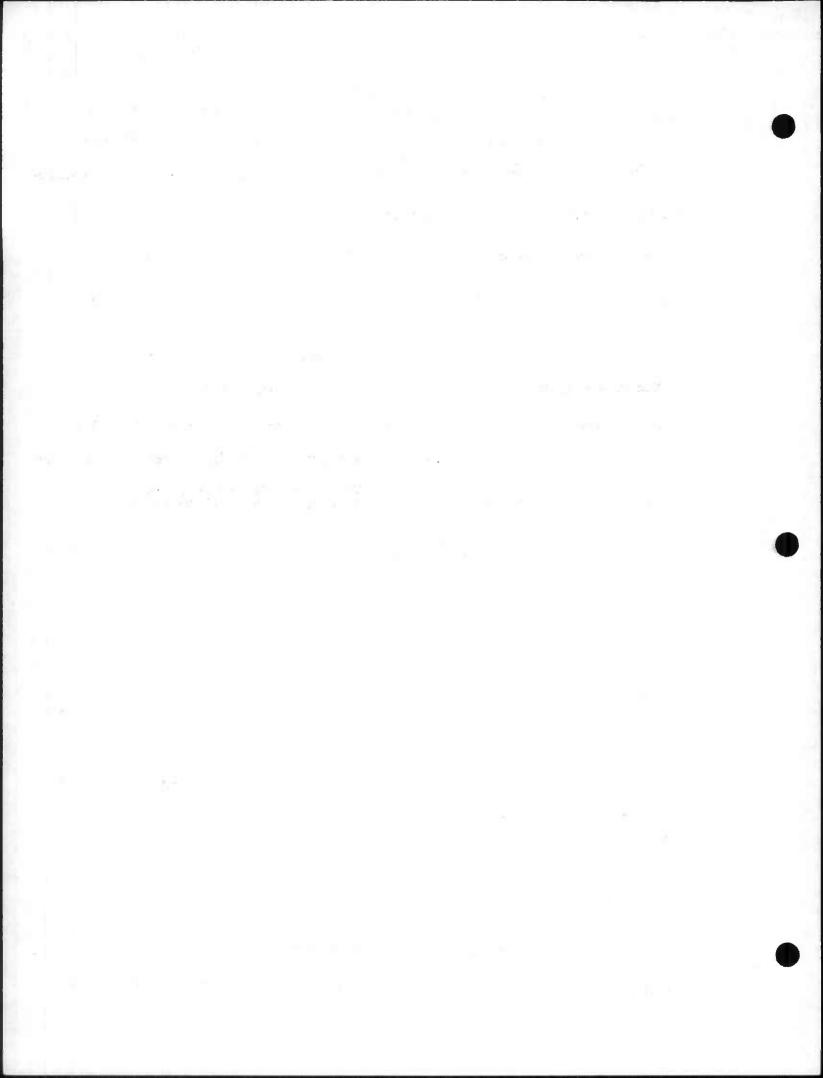
	DANT					Certificate of	f Death		Reg. No.							
			1. Decedent's Name (First, Middle, Li			-		2. Date of De	eth		3. Time of Deeth					
	Physici /Medi		SHIRLEY	DANTZL	ER			Month JULY	Dey 7	Year   997	3:35P.M					
7	Examir		4e. Fecility Name (If not institution, git	ve street end number)			4b. City, Town, or			y of Deeth	1 3:33P.M.					
		Щ	522 N.CARROLLT	IORE		NA										
	Funeral Director			Sex 7. Age (In)		thday) If Under 1 Ye  Months Day		8. Date of Bird (Month, De	y Year 1937		plece (Stete or Foreign ntry)					
	/lend		10a. State 10b. County	/ 10c.	City, Town	n or Location				1	0d. Inside City Limits					
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	or 28	ire.	10e. Street end Number	111	#	3 10f. Zip Code	•		10g. Citizen of	Whet Cour	ntry?					
	23a	le	522 N. CART	oll ton Ac	1310	JE .	21217		US	B						
	tems ver m	Funeral Directo	11. Marital Status	12. Wes Decedent Ever i Armed Forces?	n U,S.	13. Was Decedent of It Yes, specify C	f Hispenic Origin? (S uben, Mexican, Puert	pecify Yes or No o Rican, etc.)		ce - Americ						
21215-0020	permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other treumatic event, if a Modical Evanting must be notified at once.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No It Yes, Give Yeer or Dates:		1 □ Yes 2021	lo Specify:		Speci		clc					
5-	natu	Completed	15. Decedent's E (Specify only highest gr	ducation ede com <i>pleted)</i>	16a.	Decedent's Usuel Occ (Give kind of work do	cupation ne during most of wor	king	16b. Kind of E							
12	withir ane.	dmo	Elementary/Secondery (0-12)	College (1-4or 5+)	E	life. DO NOT use ret	Worker		Privat	E 50	ISTAES S					
	be filed tal Hygi d other event, t	CC	17. Fether's Neme (First, Middle, Last	))	TI	014.70	18. Mother's Nar	ne (First, Middle,	Meiden Surne	me)						
an	lid be lental ked c	To Be	THOMAS ROBI	insun			HAHIE			,						
Maryland	12 should h end Mer is marke reumatic	-	19a. Intormant's Neme/Relationship	12		Mailing Address (Stre			er, City or Town							
	1 end Health em 27 ther tr		20a. Method of Disposition	1 / COUSIN		Disposition (Neme of	STIE	Date	_20c. Locetion		1					
nor	Peges nent of I int: If ite		1 Suriel 2 ☐ Cremation 3 [	Removal from State	cemeter	y, cremetory or other p	olece)	7-14-9	20c. Lucetion	mali	wn, state					
Baltimore,	artment artment ortant: I		4 ☐ Donetion 5 ☐ Other (Special Signature of Funeral Services No.		0348		ITIM CTANS tress of Facility C	KN	200	10111	Hary! A					
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Г			23e. Part. Enter the disease, or com shock, or heert feilure. List only	plicetions that caused the d	eath. Do r	not enter the mode of d	lying, such es cardiac		rest,	1	Approximate Interval Between					
	Physician										Onset and Death					
	/Medical Examiner		Immediate Cause (Finel disease or condition resulting in death)  Hypertensive Arteriosclerotic Cardiovascular Disease  Pue to (or as a consequence of):													
		ē		Due t	Due to (or es e consequence ot):											
	uted d ansit	Examiner	Sequentially list conditions	b. — Due t	n (or es e c	consequence of):		-		i						
60,	tificete ba executed 1g physician end as tha buriel-transit		Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury	C												
ox 68760,	certificete nding phys use as tha	/Medical	thet initieted events resulting in death) Lest	Due to	o (or es e c	consequence of):										
Records, P.O. Box	The law requires that the death certi ate has been signed by the attending paga 2 should be datached for use a	Physician/	Part II. Other significent conditions	contributing to death but not	resulting in	the underlying cause	oiven in Part I	22h Did	ohecco ueo c	antributo to	the cause of deeth?					
Ö	t the by th	hys	and an arrangement of the state	or and a document for	rosulting in	Tille disdellying couse	given in restric				bably 4 Unknown					
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<u> </u>	The la	Con						101	res 2 No	10	Yes 2□ No					
NI a	igini: Th certificate rector, pag	Be	25. Was case reterred to medical examiner?	Hospital:			Nh	ath (Check only o								
F/	# F.	. To	No 27. Menner of Deeth	28e. Dete of Injury	2 ER/Ou	thetient 3 DOV		ome 5 Resident			1)					
Slong	of tune	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year		njury V	ork? □ Yes 2 □ No	200. D0301100 1	iow injury occu	1100						
N S	A de de de de de de de de de de de de de	Certification:	3 Suicide 6 Could not b	e 28e. Place of Injury - A	t home, fa	rm, street, tactory, offic	28			ber or Rure	I Route Number,					
ā	al or and Direct	Cert	4   Homicide	building, etc. (Spe	ecify)			City or Tov	vn, State)							
	To the Hospital of within 24 hours at To the Funeral D completely fitted	edical	29a. Certifier 1 ☐ CertifyIng Ph (Check only one) 1 ☐ CertifyIng Ph	nyelcian: To the best of my l miner: On the basis of exam end manner stated.	knowledge ination end	, deeth occurred at the d/or investigetion, in my	time, date end plece y opinion, deeth occu	, end due to the rred et the time,	cause(s) and m date end place,	enner es st end due to	eted. the ceuse(s)					
	Within To the	Me	29b. Signeture end title of certifier	1300		29c. Lice	nse number		29d. Date sign	ed (Month,	Dey, Yeer)					
	^		Theoreton U		ULY 8	199	7									
	1		30. Name end eddress of person who	completed duse of death (	) Item 23e) (		C.M.E.		OUL U	, 200						
	1		Theodore King				Street,	Baltimo	ore, M	aryla	and 21201					
	Sta Registr		31. Date tiled (Month, Day, Year)  JUL 1 5 1997	Registrar's Si	gneture	ndelle										



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Certifica	te of	Death		Re	g. No.			
			1. Decedent's Neme (First, Middle,	Last)						ate of Death	1		3. Time	of Death
	Physic /Medi		WILMA B			DAVIS				onth ULY	Day 13, 1	997	12:3	MA O
	Exami		4e. Fecility Neme (If not institution,	give street end number)		271112	4	b. City, Town	n, or Location		4c. Count	y of Deeth		
			Saint Joseph	Medical C	enter			Tow	son		В	alti	more	
	Funeral Director			. Sex 7. Age	(In yrs. lest birt	thday) If Und Month	er 1 Year Days	If Under 24 Hours	Hrs. 8. Da Min. (M Aug	te of Birth conth, Dey, 17,	Yeer) 1914	9. Birth Cou S •	place (State intry) Caro	or Foreign
	pe ,		Usuel Residence of Decedent				,							
	be filed within 72 hours after death with the Merylend that Hygiene. I define than "neturel", or items 23s or 28s-f show event, its Medical Examinating must be notified at	Funeral Director	Maryland N/A		10c. City, Town Balt	imore							10d. Inside 1 X Ye	City Limits
	th th	ire	10e. Street end Number			10f. 2	ip Code			10	g. Citizen of	Whet Cou	ntry?	
	th wi	ai	4426 Newport	Avenue		2	21211				U.S.	Α		
	r dea	Inel	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U,S.	13. Was Dec	edent of H	ispanic Origin	n? (Specify Y	es or No-		ce - Ameri	ican Indien,	
Maryland 21215-0020	ours afte	by	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced		0	1 □ Yes		Specify:		0.0.7	Specif		ite	
5-0	72 h	Completed	15. Decedent's (Specify only highest)	Education	16e.	Decedent's Us (Give kind of v	uel Occup	etion	f working	1	6b. Kind of B	usiness/In	idustry	
21	ithin ithin	npi	Elementery/Secondery (0-12)	College (1-4or 5-	H)	life. DO NOT	use retired	d)	Working					
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pu	d of H	Be	17. Father's Neme (First, Middle, La	st)					Neme (First		aiden Sumer	ne)		
X	Men Men arka	2	Leroy Stroud					Wi.	lma Da	vis				
Jar	2000		19e. Informant's Name/Relationship			Mailing Addre								
			Mike Davis (S	on)		113 Jef		s Cour						
Baltimore,	permit. Peges 1 an Depertment of Heel Important: If Item 2 eny Injury or other once.		20a. Method of Disposition    Burial 2 □ Cremetion 3  4 □ Donation 5 □ Other (Spe		cem eter	Disposition (Ny, crematory of 1 awn Ce	other piec		7/16		oc.Location Baltim			land
alt	mit.		21. Signature of Funerel Servica Lic	ansee /				ss of Fecility						
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			23a. Pert1. Enter the disease, or co shock, or heert failure. List on	mplications net caused	the deeth. Do n							mary.	Approxime Intervel Be	
	Physician		snock, or neer failure. List on	ly one cause on each line	9.							1	Intervel Be Onset end	etween d Death
2	/Medical		Immediate Ceuse (Final	PULMON	RV FMI	AOL ISM						1	7 Df	ays .
1	Examiner		disease or condition resulting in death)	θ										_
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	requires that the death certificate be executed seen signed by the ettending physicien end hould be deteched for use as the buriel-transit	Examiner	Sequentially list conditions	b. ————————————————————————————————————										
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Box	eath cert ettendin I for use			d	_							<u> </u>		_
	deatl	Physician/	Part II. Other elgnificent conditions	contributing to death bu	t not resulting In	the underlying	cause niv	en in Pert I	2	3b. Did tob	acco uee co	ntribute t	o the cause	of death?
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	4 E		27. Manner of Deeth	1 Inpatier	28b. T		NOA	4 LI NUISI	ing Home 5		v injury occu		ly)	
No.	ding After After	tior	1 Neturel 5 ☐ Pending 2 ☐ Accident Investigat	(Month, Day	Year) In	njury M	28c. Injury Work	k? Yes 2⊡No	Į		,,			
Division	Artenic death	Centification:	3 ☐ Suicide 6 ☐ Could not	be One Diese of Iniv	rv - At home, far					cation (Stre	et and Numi	ber or Run	e/ Route Nu	mber.
6	· 一	ent	4 ☐ Homicide	building, etc.	(Specify)	m, on oon radio	.,,		Ci	ty or Town,	Stete)			,,,,,,
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Voor FANNIE MAE DISNEY JULY 10 1997 7:40 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖫 F 212-50-4264 90 Yrs Director Sept.12,1906 MARYLAND Usual Residenca of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f sho traumetic event, the Medical Examinar insist be notified at Y Yes 2 □ No n/a Director MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2718 Hampden Avenue 21211 Funeral 12. Was Decedent Ever in U,S. Armed Forces?, 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filled within 72 hours effer c. Department of Health and Mental Hygiana. Innortant: if item 27 is merked other than "natural", or item any injury or other traumatic event, the Mental and once. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ ¥No Specify: WHITE þ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James E. Wilson Laura V. Sunderland 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Alan L. Monte-Griffo/Nephew 8 Chamaral Court, Cockeysville, MD 21030 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 14 July 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Meadowridge Cemetery 1997 Elkridge, MD 21. Signature of Funeral Servica Licensee

Victor Lengrand, Jr. 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Applications that caused the death. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) 3 DAYS SUBDURAL HEMATOMA Examiner Due to (or es a consequence of): Examiner the daath certificate be axecuted bunel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or es a consequença of): Box 68760. physiclan Physician/Medical the Due to (or as e consequenca of). 89 980 ò P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ALZHEIMER'S DISEASE Bivision of Vital Records, þ 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed peeu 2**X** No 1 ☐ Yes 2 No certificeta Mending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation Affer 1X Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide or after Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) end menner es steted.

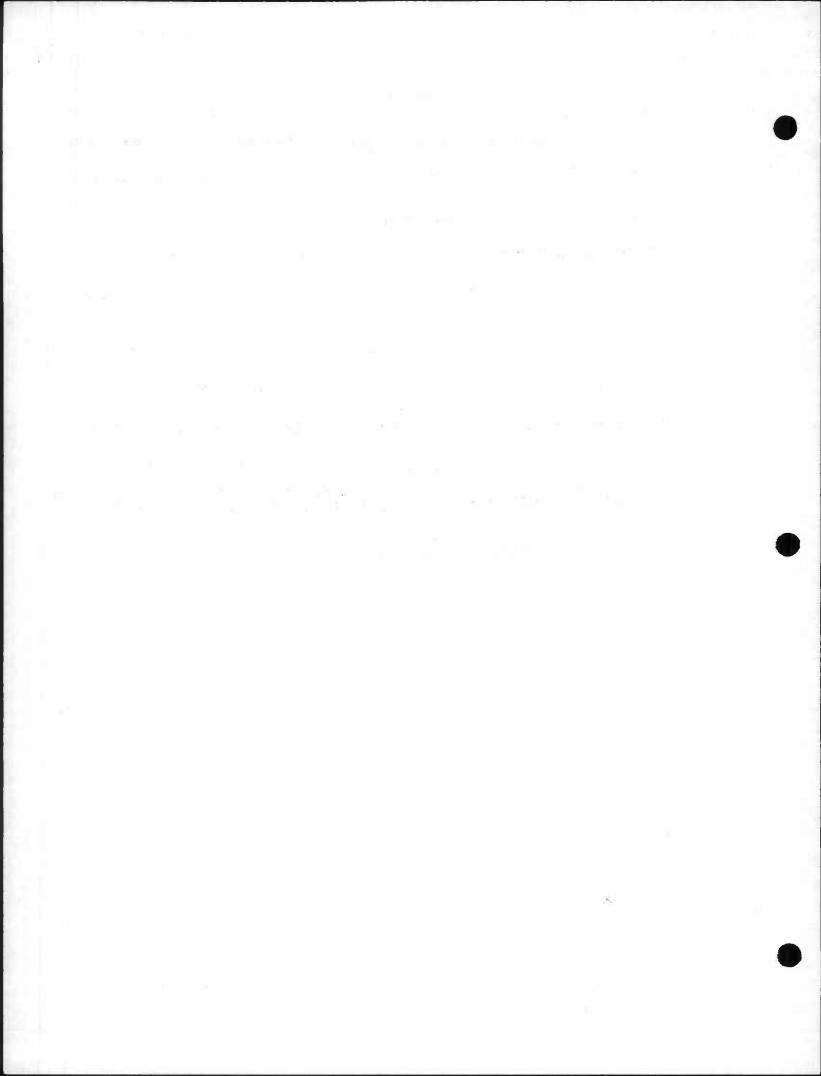
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) multa mo D41410 30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

JUL 1 5 1997

31. Date filed (Month, Day, Year)

<u> JOGINDER P. MEHTA M.D. 7620 YORK ROAD, TOWSON MARYLAND 21204</u> 32 Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 97

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death **Physician** Month Vaar EISENBERG CELIA JULY 11-30 AM. 1997. /Medical 4a. Facility Name (If not institution, giva straet and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE LEVINDALE 5. Sociel Sacurity Number if Under 1 Year if Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) Birthpiaca (State or Foraign Country) 6. Sax 7. Aga (In yrs. last birthdey) **Funeral** Days 215-22-6524 1□ M 2□ F Yrs. Director 96 JAN.26,1901 **ENGLAND** the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Madical Examinar must be notified at Director 1 ☐ Yes 2 ☐ No N/A BALTIMORE 10e Street end Number 10f. Zip Coda 10g. Citizen of What Country? death with 2500 W. BELVEDERE AVE. 21215 USA Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Bleck, Whita, atc. permit. Pagas 1 and 2 should be filed within 72 hours aftar c. Department of Haalth and Mantal Hygiena. Important: If itam 27 is marked other than "natural", or hear any injury or other traumant. 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: by Specify: 3X Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) Collega (1-4or 5+) HOMEMAKER OWN HOME 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meiden Surname) Be ISAAC REBECCA RUBINSTEIN 19e. informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) MRS. PHYLLIS STEINBERG (DAUG.) 124 STRONGWOOD RD. OWINGS MILLS, MD 21117 20b. Placa of Disposition (Neme of cematary, cramatory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stata MOSES MONTEFIORE WOODMOOR HEBREW 7/10/97 BALTO., MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funarai Sarvica Licansee 22. SOL antievinson BROS., INC. HUUMOON 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23e. Pert1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata intervel Between Onsat and Death **Physician** /Medical Immediata Causa (Finai disaasa or condition rasulting in death) MYOCARDIAL INFARCTION Examiner Examiner ATHEROSCLEROTIC CARDIOVASCULAR burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Ceusa (Disaasa or injury that initiated evants rasulting in death) Last and physician s tha bunal Records, P.O. Box 68760. Physician/Medical Dua to (or es a consequance of): Pert ii. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? Completed 1 ☐ Yas 2 No cartificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this cartifica 25. Was casa referred to medical Be 26. Placa of Death (Check only ona) Hospitai: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) P 1 ☐ Yas 2 No funeral 27. Manner of Death 28a. Data of injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? 28d. Dascribe how injury occurred Certification: 5 Panding invastigation 1 Naturel 1 Yas 2 No 2 Accident 6 Could not be 3 Suicida 28e. Piece of injury - At homa, farm, streat, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 1 Certifying Physician: To the best of my knowledga, daath occurred at tha time, date and placa, and dua to tha causa(s) and menner as steted.

2 Medicat Examiner: On tha besis of examinetion end/or invastigation, in my opinion, daath occurred at tha tima, data and piaca, end dua to tha causa(s) end mennar stated. Medicai 29a. Certifia: pletaly (Check only 29b. Signeture and title of certifier 29c. Licansa number ATTENDING 29d. Date signed (Month, Dey, Year) D 25610 PHYSICIAN 30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print) SET 2434 WEST BELVERDERE LEVINDALE BALTIMERE AVENUE 31. Date filed (Month, Day Year)
JUL 1 5 1997 State

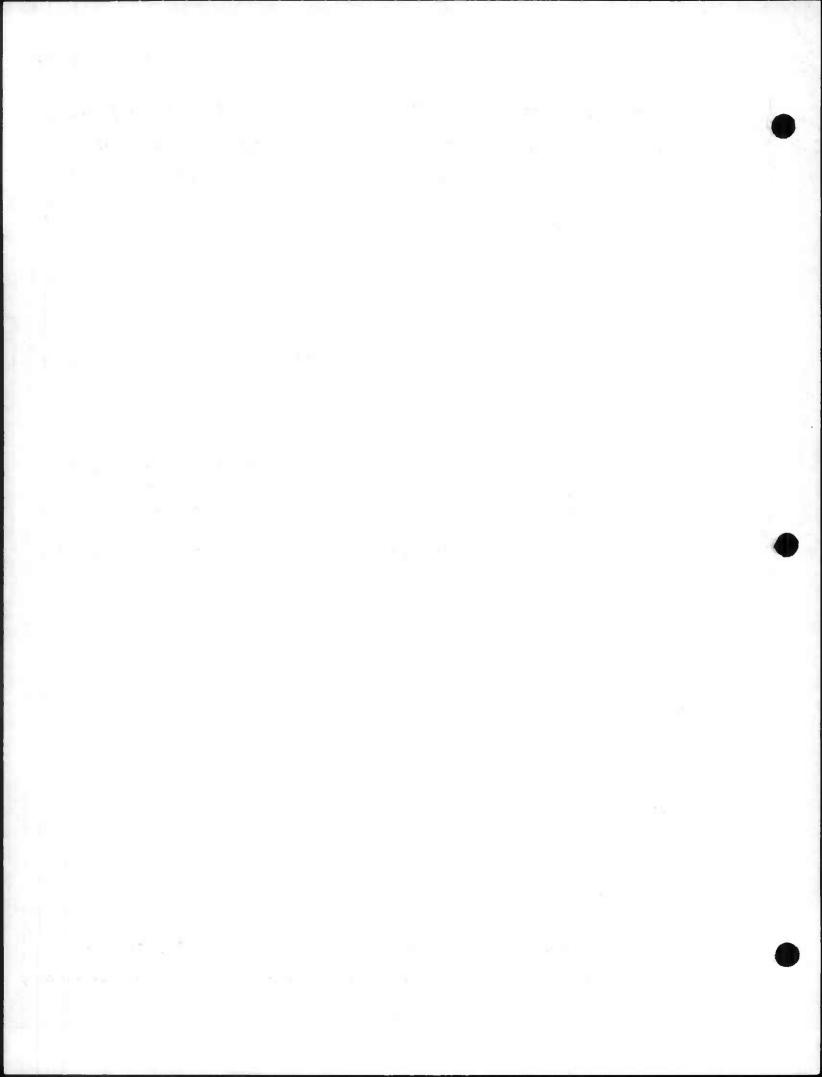
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State of Maryland / Department of Health and Mental Hygiene 97 2 1 3 5 9

			Certificate of Death Reg. No.										
	Physic	ion	1. Decedent's Nem	e (First, Middle, La	,		0 0			2. Dete of D Month	eath Dey	Yeer	3. Time of Deeth
	/Medi		MAT	JOR	IE E.	Et	PL	E		2014	13	1997	0030
	Exami		4e. Fecility Neme (/	f not institution, gi	re street end number)				4b. City, Town, o	Location of Dec	th 4c. Count	y of Death	
			SHADY G	ROVE ADV	ENTIST HOS	PITAL			ROCKV	ILLE	MON	TGOME	RY
	Funeral		5. Social Security N			(In yrs. lest b		If Under 1 Year Months Deys		8. Date of Birth 9. Birthplace (St (Month, Day, Year)			place (State or Foreign
	Director		018-10-4		10 M 20 F	81	Yrs.	OCT 17, 1915					
1	Due ≱_		Usuel Residence of 10a. Stete	10b. County		10c. City, To	wn or Loc	ation					0d. Inside City Limits
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	or 28	Director	10e. Street end Number				10f. Zip Code				10g. Citizen of Whet Country?		
	23a c	aiD	608 Crocus Drive				20850				USA		
72 hours efter death with the Merylend	9 5	Funeral	11. Marital Status		12. Wes Decedent E Armed Forces?	Ever in U,S.	13. W		Hispenic Origin? ( een, Mexican, Pue	Specify Yes or N		14. Race - American India Bleck, White, etc.	
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	ral;	d by	3√2 Widowed	4 Divorced							Specia	w: Wh	ite
	netu	Completed	(Spec	15. Decedent's E	ducation ade completed)	16	16e. Decedent's Usuel Occupation (Give kind of work done during most of working)			orkina	16b. Kind of E	16b. Kind of Business/Industry	
	9.6	idm	Eiementery/Seco	ndary (0-12)	College (1-4or 5-	-	Business Manager 18. Mother's Name						
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	Mental F Merkad of	Be	17. Father's Name									name)	
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es 1 er	Heelth em 27		20e. Method of Disp		21/8011			rocus			e, MD		
	or or or		1 Burial 2	Cremetion 3	Removal from State	20b. Plece of Disposition (Neme of cametery, cremetery or other place)		Dete	20c. Location - City or T				
	tant			5 Other (Special		Metr	Metro Crematory, Inc. 7/				Balti	more	, MD
	Depertment Important: I any Injury o		21 Signatula of Ermanal Canning Loancob \ (22 Name and Address of English						etv of	Marvl	and	Inc	
	20200	Ш	23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, intervel Between Intervel Between										
			23e. Pert 1. Enter the shock, or hear	në diseese, or com nt failure. List only	iplications that caused one cause on each lin	the death. Do	not ente	r the mode of dy	ng, such es cardi	ac or respiretory	errest,		Approximate Intervel Between
	hysician											i i	Onset end Deeth
	/Medical Examiner		immediate Ceuse (Final disease or condition disease or condition death)  **MASSZVE ASPIRAT.**					IRATIO	ION PNEUMONIA			E	GHR.
		_	resulting in death)  Due to (or es e consequenca of):										
3	asit as	Examiner			b								
	end end l-trar	xan	Sequentially list con if eny, leeding to im	nditions, mediate	[	Due to (or es a	r es a consequence of):						
	Iclen		Ceuse (Disease or Injury										
, , , , , , , , , , , , , , , , , , ,	ding physicien end ise es the buriel-transit	edical	that initiated events resulting in death) Lest Due to (or es e consequence of):									į	
	Se es	3	d										
	etten	ciar											
et the d	es the trie death igned by the ette be detached for	Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the causa		
904	deta deta								1	1 ☐ Yee 2 ☑ No 3 ☐ Probably 4 ☐			
3	os sign	d by								24a Wa	s en eutopsy	24b. W	ere eutopsy findings
ding Physician: The law requires that the death	peen si should	lete									formed?	ev	elleble prior to mpletion of cause
	has 9e 2	Completed											deeth?
											Yes 2 No	1 [	Yes 2 No
	s certific director,	Be	25. Wes case reference exeminer?		Hospital:			_ Ot	hor:	eath (Check only			1
5	= 5 0	. To	1 PYes 2 □ 27. Menner of Deat		1 28a. Dete of Injury		utpetient Time of	3LI DOA	4 Li Nursing		sidenca 6 Ott		(N
To the Hospita for Attending within 24 hours after death.	eath. or: After the funer	Certification:	1 Naturel	5 Pending investigatio	(Month, Day	(Month, Day Year) Injury Work?  M 1 ☐ Yes 2 ☐ No			200. Describe	28d. Describe how injury occurred  28f. Location (Street and Number or Rurel Route Number,			
	1 th	Ical	2 ☐ Accident 3 ☐ Suicide	6 Could not b	On Diese of Injur				28f Location				
	A C	ertit	determined  determined  determined  determined  determined  determined  determined  determined  determined  building, etc. (Specify)							City or Town, Stete)			
/	within 24 hours after		29a. Certifier 1 [Certifying Physicien: To the best of my knowledge death occurred at the time, data and place, and due to the cause(s) and manner as stated										
2	etely etely	edical	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the cause(s) end menner es stated.  2 Medical Examiner: On the basis of examination end/or Investigetion, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner es stated.								the ceuse(s)		
4	om pl	Me	29b. Signature end title of cartifier 29c. License number					se number	29d. Dete signed (Month, Dey, Year)				
F	- <b>≯ ⊩</b> Ó		Sahg. mg. mo - Attending 023630							July 13, 1997			
	10		30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)										
	(		FRANK S			eth (Item 23e)	FR.	EDERZO	K ROAL	# 213	GATTHER	SBUR	6, MD 20879
	Sta	ite	31. Date filed (Mont	h, Day, Year)		r's Signeture							
	Registi		JUL 1	5 1997	Julia Davi		dell						
			and and		161								

DHMH 16 Rav 6/95



1997

4c. County of Deeth

April20,1933 Maryland

3. Time of Death

20:15

10d. Inside City Limits 1 ☐ Yes 2 X No

2. Dete of Deeth

Month

4b. City, Town, or Location of Deeth

BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year)

		filed within 72 hours aftar death with the Hygiene. there than "natural", or ferms 23s or 28 ent, the Manical Examinar must be not	rai Dire	10e. Street end Number		10f. Zi	10f. Zip Code			10g. Citizen of Whet Country?	
				245 5th Avenue		21	227	Uı	United States		
	020		Funeral	11. Maritel Status 1 ☐ Never Married 2 ☐ Married		edent of Hispanic Origin? ecify Cuben, Mexicen, Pu	(Specify Yes or No- erto Ricen, etc.)	14. Race - An Black, Wh	mericen Indien hite, etc.		
			Completed by	3 ଔ Widowed 4 ☐ Divorced	1 ☐ Yes	2⊠ No Specify:		Specify: white			
	21215-0020			15. Decedent's E (Specify only highest gra	16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry			
		12 should be filed within h and Mantel Hygiane. 7 is marked other than "traumatic event, the Max	mo	Elementary/Secondery (0-12)	College (1-4or 5+)	homemak			wn home		
	pu	other vent	Bec	17. Father's Name (First, Middle, Last	)		18. Mother's N	lame (First, Middle, Mai	den Sumeme)		
	Maryland	Ment Ment arked	T <sub>0</sub>	Milton Houck	a Shilow						
	lar	2 shd end is me		19e. Informant's Name/Reletionship			s (Street and Number or				
	Baltimore, A	Pages 1 end nent of Healt int: If Itam 2 iry or other		Dawn Sipes, daughter 245 5th Avenue Lansdowne, Maryland 2							
				20e. Method of Disposition  1X Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Loudon Park Cemetery 7/17  Baltimore,							
	alt	permit. Depentre Imports any inju		21. Signature of Funeral Service Lice	nsee		nd Address of Fecility				
		20 5 5 8		1 Want	Animose	Ambr	ose Funera Hammonds	1 Home of	f Lansd	lowne 227	
		Physician		23a. Pert1. Enter the disease, or com shock, or heart feilure. List only	plicetions that caused the death one ceuse on each line.	n. Do not enter the mo	de of dying, such es cerd	iac or respiretory errest,	, ZI	Approxin Intervel I Onset er	
, h	¥	/Medical Examiner		Immediete Cause (Final diseese or condition resulting in deeth)	a ASYSTOLE	DUE T	D CONGES	STIVE HEA	RT FAILL	AE 30	
			<u>-</u>	Due to (or es e consequence of):							
			Ę		6 CHRONIC RENAL FAILURE 20						
	Ċ,		Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or es e consequence of):						
2	68760,		Physician/Medical								
2	99	rtifice ng ph	Med	resulting in deeth) Last		,					
W	Box	th ce tendii	lan/		d					1	
7	0	<ul> <li>Hospital or Attending Physician: The law requires that the death certificate be assocuted in 24 hours after death.</li> <li>Funeral Director: After this cartificate has been signed by the ettending physician and platsly filled in by the funeral director, page 2 should be datached for use as the bunal-transit.</li> </ul>	/sicl	Part II. Other significant conditions of	23b. Did toba	23b. Did tobacco use contribute to the cause					
70	0		by Phy	1 Nos 20					2□ No 3□	Probably 4	
ULKNER ,	ecord		Completed b					24a. Wes en e performed		o. Were eutops eveileble pri completion of of deeth?	
2	- B		E OC					1 ☐ Yes	2 No	1 ☐ Yes 2	
7	of Vital Records,		Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)						
AC			L 2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify						
F			ation:	27. Manner of Deeth  1 ☑ Naturel 5 ☐ Pending  2 ☐ Accident investigation	(Month, Dey Year)	28b. Time of Injury M	28c. Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred		
NAME:	Division		Certificatio	3 Suicide 6 Could not b	e 28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street, factor	y, office	28f. Location (Stree City or Town, S	t and Number or i itate)	Rural Route N	
NA			edicai C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner as stete (Check only one)  29 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the and manner stated.							
		a du	Me	29b. Signature end title of certifier	and married diagon.	29	c. License number	29d.	Date signed (Mo	nth. Dav. Year	

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signeture

Sechia Davidson

MAZEN GHANIM.O.

1 5 1997

31. Dete filed (Month, Dey, Year)

1. Decedent's Name (First, Middle, Last)

ST. AGNES

5. Sociel Security Number

Maryland

10a State

219-28-9857

Usual Residence of Decedent

Joyce May Faulkner

10b. County

4e. Fecility Neme (If not institution, give street and number)

HEALTHCARE

1 □ M 2√2 F

Baltimore

7. Age (In yrs. last birthday)

64

Yrs

10c. City, Town or Location

Lansdowne

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

14. Race - American Indian, Black, White, etc. Specify: white 16b. Kind of Business/Industry own home Maiden Sumeme) r, City or Town, State, Zip Code) , Maryland 21227 20c. Location - City or Town, State Baltimore, Maryland of Lansdowne oad 21227 Approximate Intervel Between Onset end Death ART FAILURE 30 YEARS 20 YEARS 45 YEARS EASE obacco use contribute to the cause of death? es 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? en eutopsy med? 2 Nio 1 ☐ Yes 2 ☐ No 7e) ence 6 ☐Other (Specify) ow injury occurred treet and Number or Rural Route Number, n, State) euse(s) end menner as steted. late end place, end due to the ceuse(s) 29d. Date signed (Month, Day, Year) P10873 JULY 13,1997 ST. AGNES HEALTHCARE 900 CATON AVE, BALTIMORE, MD, 21229

State Registrar

State of Maryland / Department of Health and Mental Hygiene

_							Ce	rtificate d	of Death	7		Reg. N	lo.		Sheet 6	
т	Division		1. Decedent's Name (First, Mic	ddle, La	ist)						2. Dete of				3. Time	of Deeth
	Physic /Medi		Maud E. F	eat	cher						Month 06	1 -	Day 7 1	997	12.2	4P.M
	Exami		4e. Fecility Name (If not institu	tion, giv	re street end nur	nber)			4b. City. T	own, or L	ocation of D	-		y of Deeth	14.6	AL . M
	LAUIIII	1161	Cuppett W				omo									
-		_	5. Social Security Number	4		7. Age (In yrs.		If Under 1 Ye		akl or 24 Hrs.		Diah	Gar	rett		
	Funeral		232-10-3656		1□M 2√2F		90 Yrs.	Months De		Min.	8. Date of Month.	Dey, Yes	76	9. Birthp	lece (Stete	or Foreign
	Director				Λ		90 113.				11-1	9-19	00	EGI	DII, V	VV
	and *		Usuel Residence of Decedent  10a. State 10b. Cour	ntv		10c Ci	ty, Town or Lo	ocation							011	0:
	aho aho	2													Od. Inside (	
	8e-f	ç	Md. Ga	rre	CC	08	akland	I							X Ye	s 2 No
	or 2	Director	10e. Street end Number					10f. Zip Cod				10g. C		What Coun	try?	
	23a	ai	706 E. Al	der	St.			2	1550				U;	SA		
	dea dea	Funeral	11. Maritel Status		12. Was Dece	dent Ever in U		Wes Decedent	of Hispenic O	rigin? (Sp	pecify Yes or	No-	14. Ra	ce - Americ	en Indien,	
0	or ite		1 Never Married 2 M	arried	Armed For	2 No		If Yes, specify C			Hicen, etc.)		Bla	ck, White,	etc.	
02	urs urs	b	3 Widowed 4 □ Divorc	ed	If Yes, Giv Year or Da	0		1□ Yes 2[X]	No Specify	<i>'</i> :			Specif	v: Wh:	ite	
Maryland 21215-0020	n 72 hours efter death with the Meryland "natural", or items 23a or 28e-f show social Examiner must be routified at	Completed	15. Deced	ent's E	ducation		16a. Deced	dent's Usuel Oc	cupation			16b	Kind of B	usiness/înc	fustry	
75	C * 6	pie	(Specify only high				(Give	kind of work do DO NOT use re	ne during mo	st of worl	king				,	
21	filed within Hygiene. ther then "	E	Elementery/Secondary (0-12	)	College (1	-4or 5+)	F	Housew	ife			0	wn l	Home		
ס	Hyge H		17. Father's Name (First, Middl	e. Last	)					er's Nam	e (First, Mid					
an	0 % D	o Be	Daniel Gr	ant	Judy						el W			,,,,,		
2	should by	F					1	1711007.40								
Ma	2 0 0		19a. Informent's Neme/Relatio Arnold G.	rsnip (	ather		19b. Mailir	2929	eet end Numt []nder:	veror Ru	Route Nu	m <i>ber, City</i>	or Town	, Stete, Zip	Code)	
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altimore,	if ite		20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation		Domouni from 6			sition (Neme of netory or other		İ	Dete	20c.	Location	- City or To	wn, Stete	
E	Pag int: i		4 Donetion 5 Other				aple S	Spring	S		6-21	E	a101	a, WY	7	
alt	permit. Pages 1 en Depertment of Heal important: If item 2 any injury or other once.		21. Signature of Juneral Service	e Licer	1500			. Neme end Ad		lity						
m	Depermination of the second of		1 - laget	CX.	1.100		I	Hinkle	Fune	ra1	Home					
-		-	23a. Pert1. Enler the disease, shock, or heert feilure. Li	Y	LINE	7	I	30x 18	6, Da	vis	WV	2626	0			
			shock, or heart feilure. Li	or com st only	piicetions that ca one ceuse on ee	used the deat ech line.	h. Do not ent	er the mode of	dying, such es	cerdiac	or respiretor	y errest,			Approxima Intervel Be	ite etween
	Physician	У.													Onset end	Deeth
	/Medical Examiner		Immediate Ceuse (Finel disease or condition		Con	gesti	ve He	art Fa	ilure					2	Mon	ths
	Examiner		resulting in death)		в	Due to (o	r es e conseq	uence of):								
	n =	ner			Cor	onary	Arte:	ry Dis	ease					Y	ears	
	certificete be executed ding physician end ise es the buriel-transit	Examiner	Sequentially list conditions		b. ———	Due to (o	r es e conseq	uence of):								
o	an ar	E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury			,	,									
68760,	e be	/Medical	thet mitiated events	<	C	Due to /o	r es e conseq	unnen offi								
9	fice g ph	Pa	resulting in death) Last			D06 t0 (0	es e consequ	uerice oi).								
		\$		-	d											
ň		Physician														
P.0.	0 0 0	ysi	Part II. Other significant condi-	tiona co	ontributing to dea	ath but not resi	ulting in the ur	nderlying ceuse	given in Pert	l.	23b. D	ld tobacc	o uee co	ntributa to	the cause	of death?
J	d by		Alzheimer	¹s	Dement	ia					1	☐ Yes	2℃ No	3□ Prob	ably 4	] Unknown
ທົ	The law requires thet the ste has been signed by the page 2 should be deteched.	by														
20	v require been si should	Completed	Periphera	1 V	ascula	r Dis	ease					es en euterformed?	opsy		re eutopsy ileble prior	
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ē	n: T ficet or, pe	O	DE Manager and the St.								_1	☐ Yes	2XO No	1	Yes 2	J No
Division of Vital Records,	Physician: rthis certific rel director,	00	25. Wes cese referred to media exeminer?	al	Hospital:				241		h (Check on					
0	this el di	7	1 ☐ Yes 2 ☒ No		1 L In	·	ER/Outpetien	1 3D DON		ursing Ho	me 5 R				)	
<u> </u>	uner uner	on:	27. Manner of Death 1 ☑Neturel 5 ☐ Pend	ling	28e. Dete of (Month)	l Injury n, <i>Dey Yeer)</i>	28b. Time of Injury	28c. Ir	jury et vork?		28d. Describ	e how inj	ury occur	red		
0 .	Attending or death. octor: After by the fune	ati	2 ☐ Accident inves	tigation				M 1	☐ Yes 2☐	No						
<u> </u>	l or Attending efter death. Director: After I in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined	200. PIECE (	of Injury - At ho	me, farm, stre	et, factory, offic	00		28f. Location	(Street e	nd Numb	er or Rurei	Route Nur	n <i>ber</i> ,
<u>.</u>	s efter s efter s Direct	Cer			Dandari	g, oto. (opoon)	7				Only of	own, old	.0)			
	hour hour hour y fill		29a. Certifier 1 Certify	ing Phy	yeician: To the b	est of my know	wledge, deeth	occurred et the	time, dete en	nd plece,	end due to ti	ne ceuse(	s) end me	enner es ste	eted.	
	of the Mospital or Attending Physician: The law within 24 hours efter death.  To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	edical	(Check only one) 2 Medica	I Exam	iner: On the bes	sis of examinat	ion end/or inv	estigation, In m	y opinion, dea	th occur	red et the tim	e, date ar	nd plece,	end due to	the cause(	s) .
	om of the	2	29b. Signature and Itle of certifi	er /	)			29c. Lice	nse number			29d. D	ate signe	d (Month, E	Dey, Yeer)	
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	32		1	y	MP				101			- une	- I /	, 13	)	
	3		30. Neme and eddress of person								F.7* *	06	_			
			Robert M. C						, Egl	on,	WV	2671	. 6			
	Sta	te	31. Date filed (Month, Day, Yee, JUL 1	10	32. Re	gistrar's Signal	ture									
	Registr	ar	OUL I	) 13:	7/	7 una wai	4dson-90	ndelle								

160 . .

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene 0.7

		State of Maryland / Department of Certificate	
Physic	ian	Decedent's Name (First, Middle, Last)	2. Deta of Death Month Dey Yeer 3. Time of Deeth
/Medi	cal	MARY E.FISHER	July 12 1997 1426 pr
Exami	ner	4a. Fecility Neme (If not institution, give street end number)  St. Agnes Hospital	4b. City, Town, or Location of Deeth 4c. County of Death n/a
Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. lest birthdey) If Under 1 Y	eer If Under 24 Hrs. 8. Dete of Birth 9. Birtholace (State or Foreign)
Director		219-38-7578 1□ M X₩ F 94 Yrs. Months D	eer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) O2-19-03  Birthplace (State or Foreign Country) RICHMOND, VA
D .		Usuel Residence of Decedent  10e. State 10b. County 10c. City, Town or Location	
the Merylen r 28a-f show	5		10d. Inside City Limits 1 □ <b>X</b> ★ 2 □ No
the M 28a-f	Director	MD         n/a         BALTIMORE           10e. Street and Number         10f, Zip Co	
th with 23e or	Die	2300 ARUNAH AVENUE	21216 UNITED STATES
	Funerai	11. Merital Status 12. Was Decedent Ever In U,S. 13. Was Decedent Free In U,S. Armed Forcas? 13. Was Decedent If Yes, specify.	of Hispenic Origin? (Specify Yes or No- Cuban, Mexicen, Puerto Ricen, etc.)  14. Race - American Indien, Bleck, White, etc.
20 sefter dea or frems		1 Never Married 2 Married 1 Yes 2 NX	Na Specify:
15-00 72 hours "netural",	d by	APTAMOOMED 4 DIADICED ABOUT DELECT.	BLACK
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d 21215-0020 filed within 72 hours eff Hygiens ther than "netural", or mit, the Medical Exam	ome	Elementary/Secondary (0-12) Collaga (1-4or 5+) DOMEST	
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aryland should be filed and Mentel Hyg marked other umatic svent,	ToE	CLARENCE BROWN	SUSAN
0 0 0 0			reet end Number or Rural Route Number, City or Town, Stete, Zip Code)
s 1 end 27 litem 27 l		SUSAN MILLS - grand- 2300 AR daughteen of Disposition (Neme of Dispositi	UNAH AVENUE, BALTIMORE, MD 21216
		X X Burial 2 Cremation 3 Removal from State	plece)
Baltimo permit. Pages Depertment of Important: If It any Injury or once.			ORIAL 7-17-97 DUNDALK, MARYLAND dress of Fecility
Balt permit. Depertu Imports any Inju			MARCHFH4300 WABASH AVENUE
		- Compared Core	
Physician		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart feilura. List only one cause on each line.	Intervel Between Onset end Death
/Medicai		Immediate Ceusa (Finel disease or condition Gas to An Lesten	1 Blanding
Examiner		resulting in deeth)  a.  Due to (gr es a consequence of):	1) Carry
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	edicai	resulting in deeth) Lest  Due to (or as e consequence of):	
BOX 6	2	d	
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P.O.	Phy	Long of lan Hoart to be	1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
ds, P.O. lires thet the designed by the a	by	congestion of Jane	
Cord	Completed	Mabeles Mollelles	24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to completion of ceuse
Rec le lew hes b	du		of death?
Vital Rollicari Ine la certificate he rector, page		OS Was and referred to medical	1 Yes R No 1 Yes 2 No
of Vital Records, Physician: The lew requires the certificate hes been signe rial director, page 2 should be	To Be	25. Wes case referred to medical examiner?  1 □ Yes ♣️ No  Hospitel: Inpatient 2 □ ER/Outpetient 3 □ DOA	26. Piece of Deeth (Check only one)  Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)
Phys Prys erthis		27. Manner of Deeth 28a. Date of Injury 28b. Time of 28c.	Injury et Work? 28d. Describe how injury occurred Work?
DIVISION Or Attending Fefer deeth. Director: After	atio	2 ☐ Accident investigation M	WORK? 1 □ Yes 2 □ No
VIS rate recto recto	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be detarmined  28e. Place of Injury - At home, farm, street, fectory, of building, etc. (Specify)	ice 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)
Is eff			
Divisio  To the Hospital or Attendit within 24 hours effer deeth. To the Funeral Director: A completely filled in by the t	edicai	29a. Cartifier  (Check only one)  2 Medical Examiner: On the basis of my knowledge, deeth occurred et the desired of my knowledge, deeth occurred et the control of the basis of my knowledge, deeth occurred et the control of the basis of my knowledge, deeth occurred et the control of the basis of my knowledge, deeth occurred et the control of the basis of my knowledge, deeth occurred et the control of the basis of my knowledge, deeth occurred et the control of the basis of my knowledge, deeth occurred et the control of the basis of my knowledge, deeth occurred et the control of the basis of my knowledge, deeth occurred et the control of the basis of my knowledge, deeth occurred et the control of the basis of my knowledge, deeth occurred et the control of the basis of my knowledge, deeth occurred et the control of the basis of my knowledge, deeth occurred et the control of the basis of the control of the basis of the control of the basis of the control of the basis of the control of the basis of the control of the basis of the control of the basis of the control of the basis of the control of the basis of the control of the basis of the control of the basis of the control of the basis of the control of the basis of the control of the control of the basis of the control of the c	e tima, data and place, and dua to tha causa(s) and mannar as statad.  ny opinion, deeth occurred et the time, dete end place, and due to tha ceuse(s)
ithin 2 of the	¥ S	and masser states.	cense number 29d. Date signed (Month, Dey, Year)
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7		30. Nama and eddrass of person who completed cause of daath (Itam 23a) (Type, Print)	-30-17 Jung 12) 11
1		MICEHMAN MS	o, Ot. Agnes Hosp.
Chi	ate	31. Dete filed (Month, Day, Yeer) 32. Registrar's Signeture	
Sta	ALC.	1111 4 7 4007	

NAME: Fisher, Mary

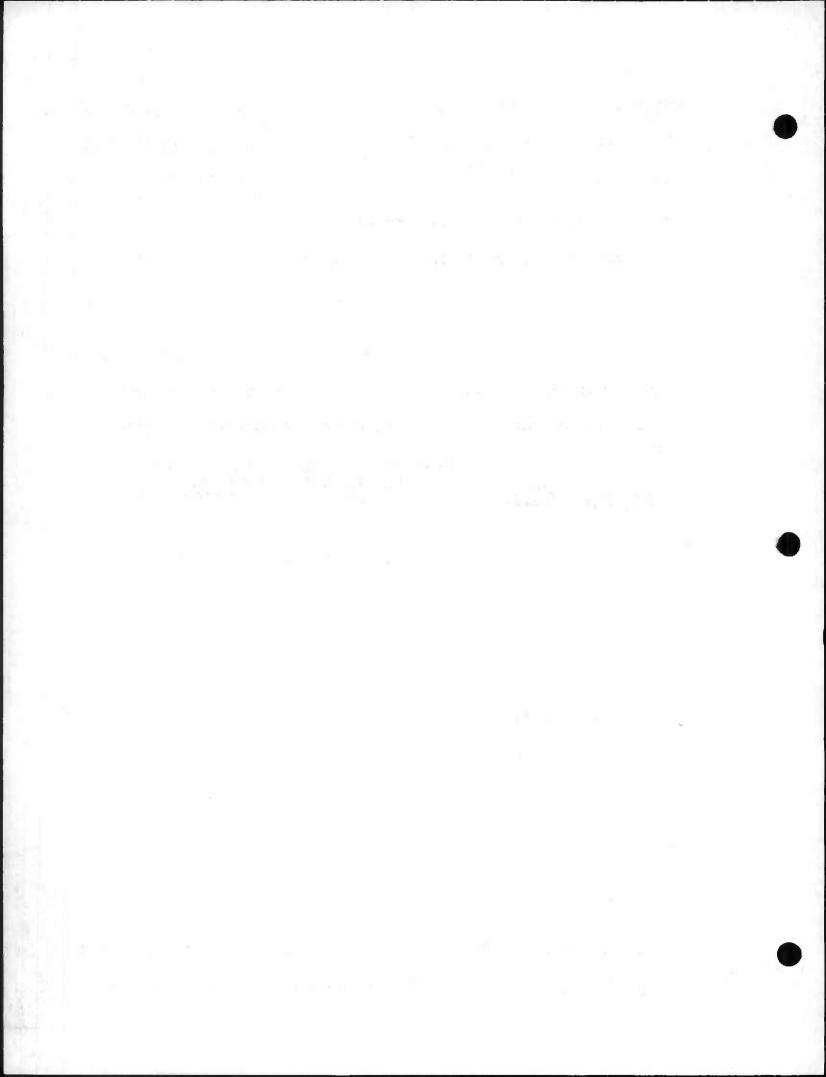
DHMH 16 Rev 6/95

NAME OF THE PERSON OF THE PERS

			State of Ma		epartment of F Certificate of			ene 9 /	21363
	Physic /Medi		Decedent's Neme (First, Middle, Last)     HYMAN		FREED		2. Dete of Deeth Month JULY 11	Day Y	3. Time of Death 3:16am
	Examir		4e. Fecility Neme (If not institution, give street end number) STELLA MARIS HOSPICE			4b. City, Town, or Lo TOWSON	cation of Deeth	4c. County of BALT	Deeth IMORE
	Funeral Director		5. Social Security Number 217–32–9130 6. Sex 1	(In yrs. lest birthd 85 Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Dey, MAY 11,		Birthplace (Stete or Foreign Country)  MARYLAND
	Maryland a-f show	tor	10a. State MARYLAND BALTIMORE	10c. City, Town or		TIMORE			10d. inside City Limits 1 ☐ Yes 2 ☐ No
	h with the	ai Director	10e. Street end Number 604 KAHN DRIVE		10f. Zip Code 212	08	10	g. Citizen of Who	
020	n 72 hours after death with the Maryland "natural", or Hems 23a or 28a-f show edical Examiner must be multiped at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Wes Decedent E  Agned Forces?  1 Payes 2 No If Yes, Give Yeer or Dates:		I3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No		ocify Yes or No- Ricen, etc.)	14. Race -	American Indien, White, etc. WHITE
Maryland 21215-0020	within sne. than	Completed	15. Decedent's Education (Specify only highest grede completed)  Elementery/Secondery (0-12)  College (1-4or 5+	(G	ecedent's Usuel Occup live kind of work done e. DO NOT use retired	during most of workii d) CFD	ng	FOOD	
land	be filed tal Hyg od other	To Be C	17. Fether's Neme (First, Middle, Last) DAVID	FREED	GRO	18. Mother's Name	(First, Middle, Ma IDA	aiden Surneme)	NKNOWN
	id 2 shifth and ith and ith and ith ith ith ith ith ith ith ith ith ith		19a. Informent's Ne <i>me</i> /Relationship (Type, Print) MRS. BETH DENNIS (DAUGHTE)		ailing Address (Street				
Baltimore,	permit. Pages 1 are Department of Hear Important: if Itam 2 any injury or other		20e. Method of Disposition  1 □ Purial 2 □ Cremation 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify)	cametery, c	sposition (Neme of cremetory or other place ISRAEL		Date 20 -13-1997		DRE, MD
Ball	Depart Import any in	-	21. Signation of Enform Sapple Licenses	_	8900 REIS	INSON & BF CERSTOWN F	ROAD PIKE	ESVILLE,	MD 21208
	Physician		23a. Part1. Enter the disease or emplications that caused to shock, or heert fall use the only one cause on each line	he death. Do not	enter the mode of dyin	g, such es cardiac o	r respiretory erres	st,	Approximete Intervel Between Onset end Death
	/Medical Examiner	er	Immediate Ceuse (Final disease or condition resulting in death)  e.	SCH- Due to (or es e con	sequence of):				
,00	cata be executed physician and the burial-transit	i Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury c.	due to (or es e con	sequence of):				
Box 68760,	that the death certificata bed by the attanding physic datached for use as the b	n/Medical		ue to (or as e cons	sequenca of):				
	death	Physician/M	Pert II. Other significent conditions contributing to death but	not resulting in th	e underlying cause giv	en in Part I.	23b. Did tob	acco uee contri	bute to the ceues of deeth?
s, P.O	S 50 00	by Phy					1 Tes	2 □ No 3	☐ Probably 4 ☐ Unknown
Records,	aw requir is been s 2 should	Completed					24a. Wes en performe		24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth?
Vital F	T ata		25 W		-		1□ Yes	2 No	1 ☐ Yes 2 ☐ No
o	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Certification: To Be	25. Was case referred to medical examiner?  1	Year) 28b. Time Injur	e of 28c. Injury	y et k? Yes 2 \( \text{No} \)	me 5 Residen 28d. Describe how	v Injury occurred	(Specify) HOSPICE
	To the Hospital of within 24 hours at to the Funeral Dompletely filled in	edical Ce	29a. Certifler (Check only one)  1 Certifying Physician: To the best of and manner state	exa <i>m</i> ination end/or	eath occurred et the tin	ne, date end place, e pinion, deeth occurre	end due to the cau ed et the ti <i>m</i> e, dat	ise(s) end menn e end place, end	er es steted. d due to the ceuse(s)
	To the within To the comple	Me	29b. Signature and title of contiller	7./	29c. Licens	2 - 10		./	Month, Dey, Year)
,	10		30, Name and address of person who completes cause of dea	nth (man Zay (Tyr	De, Print)	5 00000	DR-#2	17-10	1/971001 USON, M.S
	Sta Registr		31. Dete filed (Month, Day, Yeer) JUL 1 5 1997 Julia Devidsor	's Signeture - Pandelle		J JUNE		10 - 100	osep, med

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene 9.7

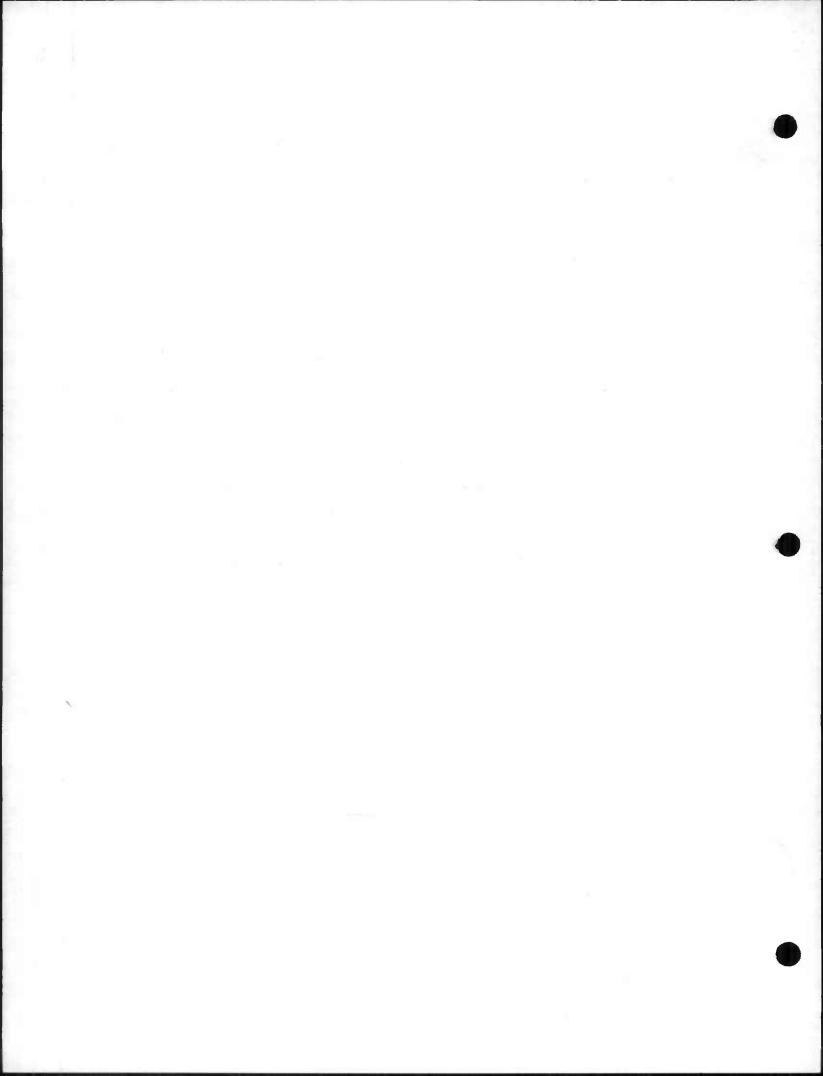
						Certific	ate of	Death		Reg. No.		21364
г	Physic	ian	1. Decedent's Name (First, Middle						2. Dete Mont		Yeer	3. Time of Death
	/Medi		MARY MAGDALEN	FEENEY						09 1	797	2 p.m.
	Exami	ner	4a. Fecility Name (If not institution	, give street end numbe	er)			4b. City, Town, or	Location of	Death 4c. Co	unty of Deeth	
			713 Maiden	Thorce L	n Apt	7611		Catons	IIIVE		ultimo	
1	Funeral		5. Social Security Number	6. Sex 7. / 1 ☐ M 2 ☑ F	Age (In yrs! last	Mon	nder 1 Year ths Deys	Hours Min	8. Date (Mont	of Birth h, Dey, Yeer)	9. Birth	plece (State or Foreign htry)
l,	Director		212-10-2373	1 M 2 M	86	Yrs.				10 1910		MD
	pue *		Usuel Residence of Decedent  10e. State 10b. County		10c. City. To	own or Location					1.	0d. Inside City Limits
	Aaryt Faho	5		MTMODE:			_					1 ☐ Yes 2 ☒No
	the Marylan 28a-f ahow notified at	Director	10e. Street end Number	TIMORE	CAI	CONSVILL	LE . Zip Code			10a Citizan	of Minat Cour	
	with a or	5				101				TOG. CRIZER	of Whet Cour	iti y r
	eath w	Funeral	707 MAIDEN CH	12. Was Deceder	7-G11	13 Was D		228 Hispanic Origi <u>n</u> ? (:	Spacify Vac	or No. 14	USA Race - Americ	en Indian
	iter dea	Fun	1 Never Married 2 Marri	Armed Force	s?	If Yes,	specify Cub	an, Mexican, Pue	to Ricen, etc	5.)	Black, White,	
22	within 72 hours efter death with the Maryland ilene. Then "natural", or items 23s or 28s-f show the Medical Examinet must be notified at	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates		1□ Ye	s 2□Mio	Specify:		Sp	ecify: W.H	ITE
Ģ	"natural",	Pe	15. Decedent		11	8e. Decedent's 1	Usuel Occup	petion		16b. Kind	of Business/In	
21215-0020	c = 20	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed)  College (1-4o	v. 5 . \	(Give kind o. life. DO NO	f work done Tuse retire	during most of wo	orking			
2	filed within Hygiene. other than	mo:	Clothonaly/Socondary (5-12)	2	, J+)	MA	NAGER			MOVIN	IG & SI	ORAGE
g	be filed tal Hyg d other event,	Be	17. Fether's Name (First, Middle, I	Last)				18. Mother's Na	me (First, M	iddle, Maiden Sur	neme)	
<u>a</u>	should be filed and Mental Hygi marked other imatic event, I	To	BONAVENTURE	E. von PA	RIS			TERE	SA JO	SEPHINE	ANTON	
Maryland	d 2 should be f th and Mental I 7 Is marked of traumatic eve	ľ	19a. Informant's Name/Relationsh	nip (Type, Print)	1	19b. Mailing Add	ress (Street	end Number or F	urel Route N	lumber, City or To	wn, Stete, Zip	Code)
	D = 72		ARTHUR G. FEEN	EY, SON		679 SHO	RE RO	AD, SEVE	RNA PA	RK, MD 2	1146	
ore			20a. Method of Disposition 1 ★ Burial 2 ☐ Cremetion	2 DB		e of Disposition of the of Disposition of Dispositi	Neme of or other pla	ce)	Dete	20c. Locati	on - City or To	own, State
Baltimore,	permit. Pages Department of I Important: If Ite any Injury or or once.		4 Donetion 5 Other (Sp		SACR	ED HEAR	T OF	TESUS	7-14	BALTI	MORE,	MD
a	pemit. Pag Department Important: I any Injury o		21. Signature of Funeral Service I	icensee				SATON FU				
••	825 5 8		1 Hullen	Hacks		736 I	EDMONE	SON AVE.	CATO	NSVILLE,	MD 21	228
			23a. Part1. Enter the disease, or shock, or heart feilure. List	complications thet caus	ed the death. D	Do not enter the	mode of dyi	ng, such es cardia	c or respirat	ory errest,		Approximete Intervel Between
5	Physician			any one codes on cost.							1	Onset and Death
6	/Medical		Immediate Ceuse (Final disease or condition	· Athor	090101	ntin	0050	ZOWNE	aula	r die	300	>
	Examiner		resulting in death)	0.1111		e consequence		210 1000	COIC	<u> </u>	V.C.	
	pe sit	Examiner		<b>a</b> b							,	
	and -tran										ŀ	
-	an an	X X	Sequentially list conditions,		Due to (or as	e consequence	of):					
9	D 0 0	al Exa	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury	c	Due to (or as	e consequence	of):					
38/86	cete be executed physician and the burial-transit	dical Exa	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest	c		e consequence						
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or vital Records, P.O. Box	or Attending Physician: The law requires that the death certiful death.  Jirector: After this certificete has been signed by the attending in by the funeral director, page 2 should be detached for use es	Medical Certification: To Be Completed by Physician/Medical	Part II. Other eignificant condition  Atrial fibr  Purporacy  25. Wes case referred to medical exeminer?  1   Yes   2   No  27. Menner of Deeth 1   Naturel   5   Pending investig   3   Suicide   4   Homicide   6   Could in determine (Check only one)  29b. Signature end title of certifier	Hospitel: 1 Inpa  28e. Date of In (Month, Date) ation oned 28e. Place of I building, of purpose and manner service who completed cause of 32. Regis	Due to (or as but not resulting but not resulting but not resulting but not resulting but not resulting but not resulting a bu	a consequence g in the underlying Outpetient 3 b. Time of Injury M , farm, street, factory investigation (Type, Print) Mail Consequence	DOA Otto	26. Place of Dener: 4 Nursing I Nurs	24a.  ath (Check of the content of t	Wes en eutopsy performed?  1 Yes 2 N  only one)  Residence 6 I  tribe how injury on  ion (Street end N  or Town, Stefe)  the ceuse(s) end  ime, dete end pla	24b. We ever cool of the courred to the courred to the courred to the courred to the courred to the courred to the courred to the courred to the courred to the courred to the courred to the courred to the courred to the courred to the courred to the courred to the courred to the course of the co	ere eutopsy findings eilebie prior to mpletion of cause deeth?  Yes 2 No  No  No  No  No  No  No  No  No  No
of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours effer death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use each	Medical Certification: To Be Completed by Physician/Medical	Part II. Other elgnificant condition  Atrial fibral	Hospitel: 1   Inpa  28e. Date of In (Month, Date)  and Date of In (Month, Date)  Bearing the bear of the bear of the building, of the bear of the building.  The bear of the b	Due to (or as but not resulting but not resulting but not resulting but not resulting but not resulting but not resulting a bu	a consequence g in the underlying Outpetient 3 b. Time of Injury M , farm, street, factory investigation (Type, Print) Mail Consequence	DOA Otto	26. Place of Dener: 4 Nursing I Nurs	24a.  ath (Check of the content of t	Wes en eutopsy performed?  1 Yes 2 N  only one)  Residence 6 I  ion (Street end N  or Town, Stete)  the ceuse(s) end ime, dete end pla	24b. We ever cool of the courred to the courred to the courred to the courred to the courred to the courred to the courred to the courred to the courred to the courred to the courred to the courred to the courred to the courred to the courred to the courred to the courred to the course of the co	ere eutopsy findings eilebie prior to mpletion of cause deeth?  Yes 2 No  No  No  No  No  No  No  No  No  No



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 2 1 3 6 5

	Item	:26	per ME G-749 7/15/97	dh	,	Certificate o	f Death	R	eg. No.	1 6	. 1000
	Physici	an	1. Decedent's Neme (First, Middle, Li					2. Dete of Dee		Year	3. Time of Deeth
	/Medic		Paul	Richard	Franc	ζ		July	10,	1997	~ GAM
Ž	Examir	er	4a. Fecility Neme (If not institution, gi	The second second second			4b. City, Town, or L		4c. County	of Deeth	
1		۳	10188 01d Fre		oad o (In yrs. last birth	day) If Undar 1 Yea	Ellicot ar   If Under 24 Hrs.			owar	
	Funeral Director			1][X] M 2□ F	50 Y	Months Dev		8. Date of Birth (Month, Dey, JAN 6,	1947	Count Ma	ace (State or Foreign ry) ryland
	wor =		10e. Stete 10b. County		10c. City, Town	or Location				10	d. Inside City Limits
	death with the Marylend ma 23a or 28a-f show	ctor	Maryland Howar	d		Ellico	ott City				1□Yas 2ÃNo
	章 or 28	Director	10e. Street end Number			10f. Zip Code	Э	1	0g. Citizen of V	Vhat Count	ry?
	ath w	rai	10188 01d				21043			USA	
21215-0020	or he	by Funeral	11. Marital Stetus  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 □XYas 2 □ N If Yes, Give Year or Dates:		13. Was Decedent of If Yas, specify Control of Yes 2 N N	of Hispenic Origin? (Spuban, Mexican, Puerto Io Specify:	pecify Yes or No- p Ricen, atc.)		e - Amarica ck, Whita, e	
5-0	72 hours "natural", edical Ex	eted	15. Decedent's E (Specify only highest gr	ducation ede completed)	16a. [	ecedent's Usuel Occ Give kind of work dor	cupetion ne during most of work	king	16b. Kind of Bu	usiness/Indi	ustry
121		Completed	Elementery/Secondary (0-12)	College (1-4or 5	+)		ne during most of worldired)				
	filed v Hygia ther t	CO	12 17. Father's Neme (First, Middle, Lasi	)	Hea	vy Equipme	ent Operato				ction
Maryland	ges 1 and 2 should be filed withi t of Health and Mental Hygiana. If Item 27 Is marked other than or other traumatic event, tha M	To Be	Walter Fra					ıy Car	_	Land	wehr
ary	2 shou and M is mar	<b>-</b>	19a. Informent's Name/Relationship		19b.	Mailing Address (Stre	eet and Number or Ru	-			
	1 end 2 Health ar		Louis Walter Fra	nck/brother	34	7 Town Gre	een Way Re	eisterst	own, MD	2113	6
Baltimore,	permit. Pages 1 e Depertment of Hei Important: If Item any Injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Romoval from State	20b. Plece of I cemetery	Disposition (Neme of cremetory or other p	oleca)	Date	20c. Location -	City or Tov	vn, State
Ë	Pag ment ant: I		4 □ Donetion 5 □ Other (Speci	(y)	Metro	Crematory,	Inc.	7/14/97	Balti	more	, MD
Sall	permit. Pages Depertment of Important: If Ite any Injury or of		21. Signature of Auneral Service Lice	nsee Mald		22. Name and Add	drass of Facility  Funeral	Ното	DΛ		
_	40 E 6 0		Dawn F. Mo	Donald			ederick F			e. M	D 21228
	Physician		23a. Pert1. Enter the disaasa, or con shock, or heart feilure. List only	plications that causad one ceuse on each lin	tha daath. Do no e.	t enter the moda of d	tying, such as cardiac	or respiretory error	est,		Approximete Intervel Between Onset end Death
7	/Medical Examiner		Immediete Ceuse (Final diseese or condition resulting in deeth)	· Aspl	NYXIA	by 1	Hansir	15			mnutes
		-	rooting in coolin		Due to (or es e co	nsequence of):	,	)			11
117	uted d ansit	Examiner		b. Majo	Ver	messin_				i i	Years
ó	deeth certificate be executed e ettanding physician and d for use es the burial-transit	Exa	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury		Due to (or es e cò	risequence or):				1	
68760,	ite be nysicia he bu	Medical	Ceuse (Diseese or injury that initiated events resulting in deeth) Lest	c	Due to (or as a co	nsequence of):				+	
N.4	ing ph	Med	resolving in deethy Lest	4							
Box	eeth cer ettandin I for use	lan/		d							
0	the e	Physician/	Pert II. Other eignificent conditions	contributing to death bu	t not resulting in t	he underlying ceuse	given in Pert I.	23b. Did to	bacco use cor	ntribute to	the cause of deeth?
σ.	that the ed by th detach		ashestosis.					1 □ Y	es 20No	3 Prob	ably 4 Unknown
Records,	requiras that the de been signed by the should be detached	d by						24a. Was a	n autonsv	24b. Wei	re eutopsy findings
00	w requ	Completed						perfor		ave	ilable prior to apletion of cause eeth?
	The law seta hes t pega 2 s	dmo						1 🗆 Ye	es 2000		Yes 200 No
Vital	ician: The certificeta rector, peg	Be C	25. Was cese referred to medical				26 Place of Dea	th (Check only on			165 205 110
of V	Physician: r this certifice and director, p	ToE	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatier	nt 2 ER/Outp	etient 3E DOA	Wher:	ome 5\Q Reside		er (Specify,	)
0	The th		27. Manner of Death 1 □ Naturel 5 □ Pending	28a. Dete of Injur (Month, Day		ne of 28c. In	jury et Vork?	28d. Describe he	1 1	1	
Sil		cat	2 ☐ Accident investigation 3 ☑ Sulcida 6 ☐ Could not be	2214101	97 N	7 A M 1	☐ Yes 2 ☑ No			han	•
3	7	Certification:	4 ☐ Homicide determined	28e. Plece of Inju building, etc.	. (Specify)	n, street, fectory, offic	>e	28f. Location (Si City or Town	n, State)	,	
1			29a. Certifier 1□ Certifying Pl	nysician: To the best of		teath occurred at the	time dete and place				above.
	Ho 124 Fu	edicai		niner: On the basis of end manner sta	axamination end/	or investigation, in my	y opinion, death occur	rred at tha time, d	ate and place,	end dua to	the cause(s)
	To the H within 24 To the Fu completen	Me	29b. Signature and title of certifier	_ (	Denti		ense number		9d. Date signed	d (Month, E	ley, Yaer)
			Harman S.	Lyan N	m' N	1E D	31473	>	July	11,1	1997
1			30. Name and address of person who PATIWES A. TOTO	completed dause of de	eath (Item 23e) (T				City 1	152	1042
	Sta Registr		31. Date filed (Month, Day, Yeer)  JUL 1 5 199	32, Hagustra	Surdson-	andell					



				State of Marylar		epartme Certifica				Reg. No.	2	1366
	Physic /Medi	cal		LESTON	FF	ALLS			2. Dete of De Month	9 10	ž <sup>2</sup> 7	3. Time of Deeth /035
	Examir Funeral Director	ner	4e. Fecility Neme (If not institution, give  Stage Security Number 6. Sec. 223-10-8034  Usuel Residence of Decedent	are 900 S	lest birth	on AU day) If Und Months	er 1 Year	ALTO- If Under 24 I	or Location of Deal	Balti sth. Year) 26, 1919	more	City ace (State or Foreign ny) ginia
	Maryland 4 show 3ed at	tor	10e. State 10b. County Maryland Howard		ty, Town	or Location			7-71-41-88-7-1-8-20		10	od. Inside City Limits 1 ☐ Yes ※ No
	ter death with the Marylar ttems 23a or 28a-f show ner must be notified at	Funeral Director	10e. Street end Number 5727 Landing Road	1			ip Code 227			10g. Citizen of W	het Count	ry?
020	urs after deut af, or flams 2 Examiner mu	by	11. Maritel Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Detes: 1941.		If Yes, sp	edent of Hi ecify Cuba 2₩ No	spenic Origin? n, Mexican, Pu Specify:	(Specify Yes or Neuerto Rican, etc.)	Black	- America k, White, e	etc.
Maryland 21215-0020	within 72 ho lene. than "naturi the Medical J	Be Completed	15. Decedent's Edi (Specify only highest gred Elementary/Secondary (0-12)	ıcatlon	16e F		uel Occupe rork done d use retired,	tu <i>ring</i> most of	working	16b. Kind of But	siness/Ind	ustry
/land 2	uid be filed within Mental Hygiene. rked other than dic event, the M	To Be Co	17. Fether's Neme (First, Middle, Last) Henry Otis Falls						Name (First, Middle Lee Kais		e)	
Aan	2 sho r and l ls ma feuma		19a. fnformant's Name/Retetionship (T)			•			Rurel Route Numb			,
Baltimore, I	ages 1 and 2 should rit of Health and Mer I: If Nem 27 is merks y or other traumatio		Josephine P. I	20b. Removel from Stete	Plece of [	727 Lar Disposition (N cremetory or	eme of		Baltimore	20c. Location - 0		
Baltir	permit. Page Department of Important: If any injury or once.		4 ☑ Donation 5 ☐ Other (Specify)  21. Signature of Juneral Service Licens ROT	ee 1	Dire	ctor Si	tate A	s of Fecility Anatomy	Board,	655 W. Ba	altim	ore St.
	Physician		23s. Part1. Enter the damese, of composition of heart feiture. List only of	lications that caused the dee ne ceuse on eech line.	th. Do no							Approximete Intervel Between Onset end Death
	/Medical Examiner		Immediate Ceuse (Finel disease or condition resulting in death)	e. PNE	J M	ONI onsequence of	<u>A</u>					IWEEK
	onted nd ransit	Examiner	Sequentially list conditions	SEP	SIS							WEEK
90,	a la	EX	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury			RAT	-10	N				IWEEK
ox 68760,	Evident I	VMedical	that initiated events resulting In death) Lest	·		nsequenca of	:					
Box	he atter	iciar	Pert II. Other significent conditions con	ntributing to death but not res	sulting in 1	he underlying	cause nive	n In Part I	23h Did	tohacco use con	tribute to	the cause of death?
σ.	ed by I detact	by Physician/M					ouddo give	THE STATE OF				ably 4 AUnknown
Records,	been s should	Completed !							24a. Wes	en eutopsy ormed?	con	re eutopsy findings ileble prior to apletion of cause leeth?
	# # # # # # # # # # # # # # # # # # #							_	10	Yes 2 No	1 🗆	Yes 2 No
of Vital		o Be	25. Wes case referred to medical exeminer?  1 Yes 2 No	Hospitel:	T F P / O	oniona OF F	Othe	Ar.	Deeth (Check only		. (0	
ion of	A A B	►	27. Manner of Deeth  1 XNaturet 5 Pending 2 Accident investigation	28e. Dete of tnjury (Month, Day Year)	28b. Tir	ne of ury M	28c. Injury Work	4 Li Nursin	g Home 5 Res 28d. Describe	how injury occurre		1
5	무용분드	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, fam fy)	n, street, facto	ry, office			(Street end Numbe wn, Stete)	er or Rural	Route Number,
	within 24 hours after	edical	29a. Certifier 1⊠ Certifying Physical Check only one) 1⊠ Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier 1⊠ Certifying Physical Certifier 1⊠ Certifying Physical Certifier 1⊠ Certifying Physical Certifier 1⊠ Certifying Physical Certifier 1⊠ Certifying Physical Certifier 1⊠ Certifying Physical Certifier 1∪ Certifier 1∪ Certifier 1∪ Certifying Physical Certifier 1∪ Certifier	eiclan: To the best of my kno ner: On the basis of examine end manner stated.	wiedge, o etion end/	death occurre or investigation	d et the tim n, In my op	e, date end pl inlon, death o	ece, end due to the ccurred et the time	ceuse(s) end mer date end ptece, e	nner es sta nd due to	ited. the cause(s)
1	To	Σ	29b. Signature and title of certifier	8 20	117	2	Oc. License			29d. Date signed		
			20 Nama and address of assess of	wardher	171	)	7	1087	6	JUL	1 0	9 1997 AGNES HOS
			30. Name and address of person who co				471	JARE	MD	21229	, 31.	MUTUES TO
	Sta Registr		31. Dete filed (Month, Day, Year) JUL 1 5 1997	Julia Maridiano	dure and	2.	11	- 1		2164		

NAME, HENRY P. FALLS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 7:15 A.M. THOMAS JULY 14 1997

10d. Inside City Limits

Approximete Intervel Between Onset and Deeth

1 ☐ Yes 2 No

1 ☐ Yes 3 ☐ No

**Physician** /Medical **Examiner** 

ARCSHIFFMON Dete filed (Month, Day, Year) UL 1 5 1997

1 5 1997

GNAU , SR. 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth PASADENA
if Under 1 Year If Under 24 Hrs. 1500 FAIRVIEW BEACH ROAD SLIP E ANNE ARUNDEL 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 12 M 2□ F Months Deys Hours Yrs. Director 215-34-5436 61 7/21/35 MARYLAND Usual Residence of Decedent death with the Maryland 10a Stete 10b. County 10c. City, Town or Location 28a-f show event, the Medical Examiner must be notified at Director ANNE ARUNDEL PASADENA 10e. Street and Number 10f, Zip Code 10g. Citizen of Whet Country? 6 Items 23s 1500 FAIRVIEW BEACH ROAD 21122 USA Funeral Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer or Department of Haalih end Mental Hygiene. Important: If Item 27 Is marked other than "natural", or ther any Injury or other traumatic event, the Medical Exercises. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Ď 3 ☐ Widowed 4 ☐ Divorcad WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 11th GRADE OWNER OF BUSINESS TRUCKING CO. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT J. GNAU PHYLOMENA PELISK 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) FRANCES GNAU WIFE 1500 FAIRVIEW BEACH RD. PASADENA, MD 20e. Method of Disposition Dete 20c. Location - City or Town, State Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) MOST HOLY REDEEMER CEM. 7/17/97 BALTIMORE, MD 21. Signature of Funeral Servica Licanses 2. Name end Address of Facility
JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. denia 21286 10 TOWSON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyling, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final disease or condition resulting In death) Examiner The law requires that the death certificata be executed Exami Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of) physicien at s the burial-1 Wital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 98 950 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes an autopsy page 2 1 Yes 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Netural 5 Pending 1 Yes 2 No Investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) erter Direc 4 Homicide n 24 hou. the Funeral Dis-Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signeture and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2809 BOSTON ST.

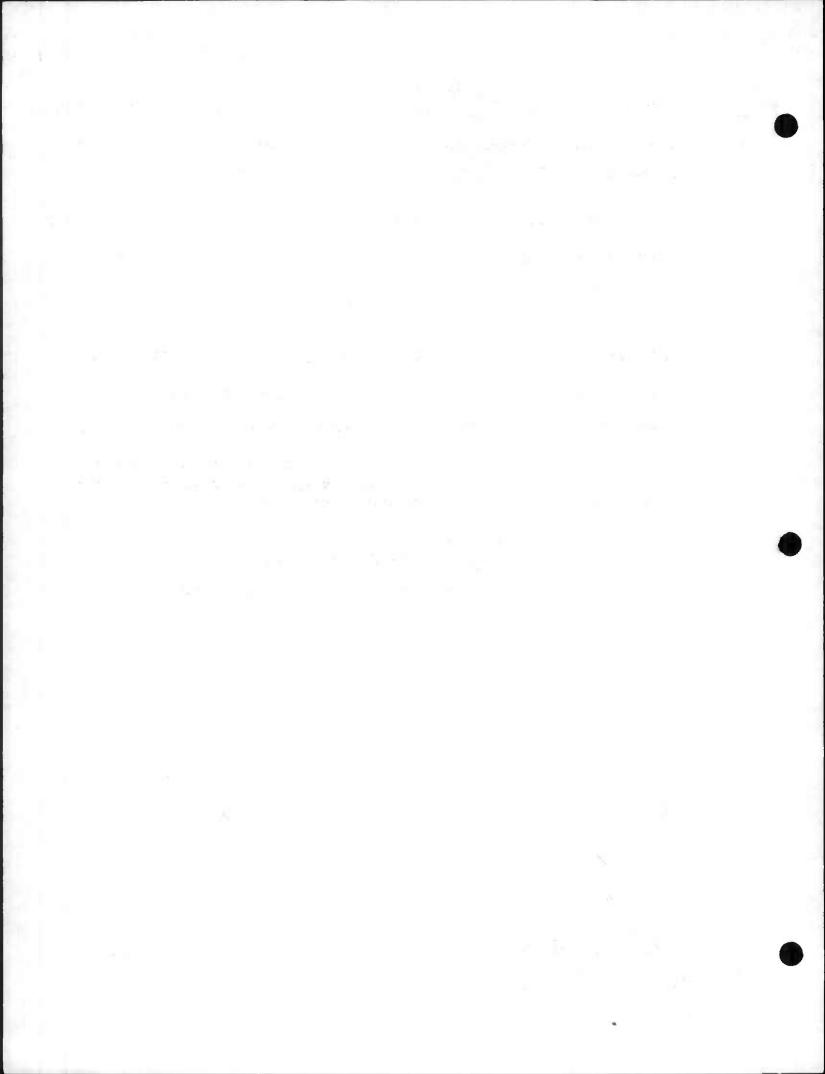
Davidson Rendere

32. Registrer's Signature

BALTIMOIZE, M.D. ZIZZY

DHMH 16 Rev 6/95

Registrar



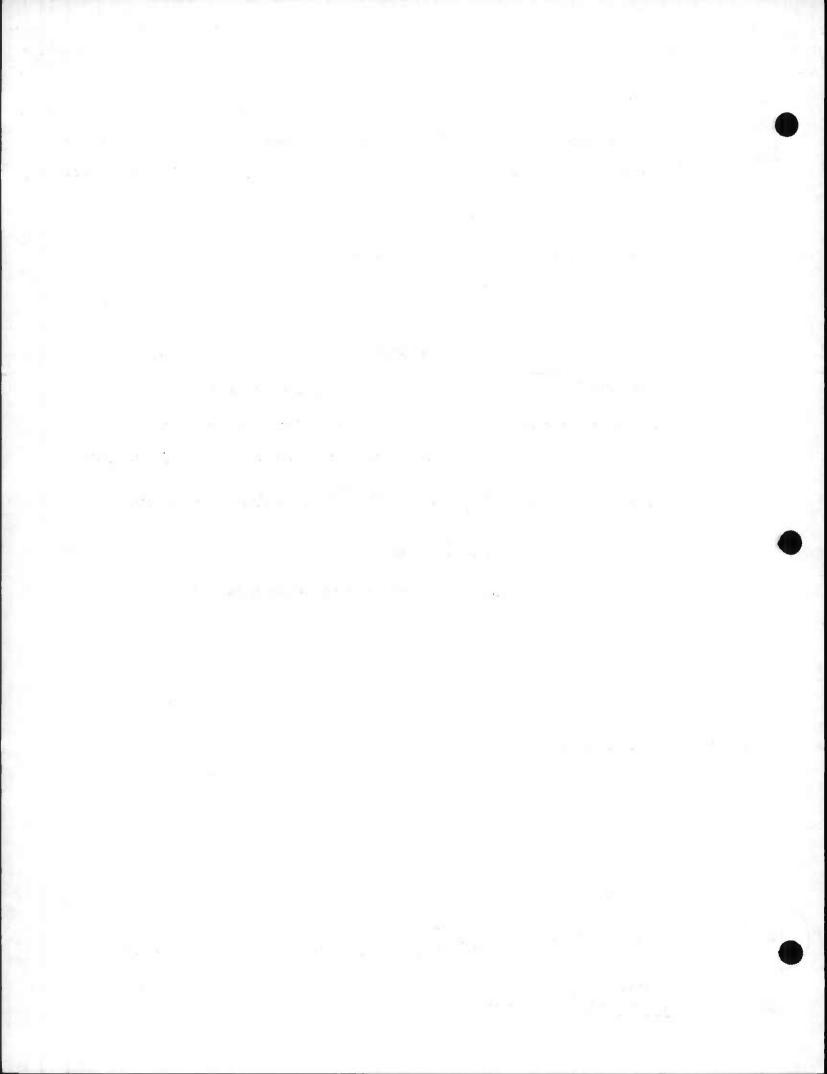
State of Maryland / Department of Health and Mental Hygiene 97

21368

						C	ertifica	ate of	Death	7		Reg. No.		
			1. Decedent's Neme (First, Middle,	Last)							2. Data of D	eath		3. Time of Death
ŀ	Physic		DYTA ONINE	CDI	1 1						Month	Day	Yaar 1997	11:45 P
7	/Medi Exami		4a. Facility Nama (If not institution,	GR I					4b. City, To	own, or Lo	ocation of Dea	11 4c. Co	ounty of Death	
1	Exami	iei	Saint Joseph			ton				owso				imore
-				. Sax	7. Age (In yrs		u If Un	dar 1 Yaai		r 24 Hrs.		int la		
	Funeral Director		264-14-3351	1 M 2 F	75 75	Yrs.	Month			Min.	8. Date of B (Month, I July 26	), Yeer) 1921	Balti	plece (Stete or Foreign intry) More,Maryland
	pur *		Usual Residence of Decedent  10a. Stete 10b. County		10c C	ity, Town or	Location						T	40d Inside Oits I twite
	anyle sho	-			100.0	ity, TOWITOI	Location							10d. Inside City Limits
	Ba-f	cto	Maryland Baltimore	e City	Balti	more								1 ☐ Yes 2 ☐ No X
	中 P P P P P P P P P P P P P P P P P P P	1	10e. Street end Number				10f.	Zip Code				10g. Citize	n of What Cou	intry?
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	des des	Funeral Director	11. Marital Status	12. Was Dece	edent Ever in U	J,S. 13	3. Was De	cedent of	Hispanic Or	rigin? (Sp	ecify Yes or N Rican, etc.)	10-	Race - Amar	
0	or its		1 ☐ Naver Married 2 ☐ Married	1 ☐ Yes	2 🛛 No						rican, etc.)		Bleck, White	, etc.
02	filed within 72 hours efter death with the Maryland Hygiena. ther than "netural", or ferms 23a or 28a-f show ent, the Medical Examinar transit be notified at	by	3 Widowed 4 □ Divorced	If Yas, Giv Year or D			1 ⊔ Yas	2 🗓 No	Specify	:		Sp	oecify: Whi	te
P	2 ho	Completed	15. Decedent's	Educetion		16a. Dec	cedent's U	sual Occu	pation			16b. Kind	of Business/Ir	ndustry
2	n n	pie	(Specify only highest ( Elementary/Secondary (0-12)		45-)	(Git	ve kind of DO NO	work done Tuse retire	during mos	st of work	ing			
2	tha	E	12	College (1 N/A	-40r 5+)	Secret	tarv					Bankin	а	
O	Hyg Hyg ther int,	Ü	17. Father's Neme (First, Middle, La			3333			18. Moth	ar's Nam	e (First, Middl			
an	od pe	Be	Joseph DePetris	•								.,	,	
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Maryland 21215-0020	han is r		19a. Informant's Name/Relationship				_						own, State, Zi	p Code)
d)	and lealt			aughter)	1001	608 F	airwa	y Dri	ive To	wson,	Marylan		·	
0	of the		20a. Method of Disposition  XX Burial 2 ☐ Cremation 3	□ Removal from	State	Place of Dis cemetery, cr	remetory o	or other pla			Dete		tion - City or T	
Ξ	Pag ment int: i		4 □ Donation 5 □ Other (Spe		St.	Joseph 1	's Chu	irch Ce	emetery	July	15, 199	7 Baltir	more, Ma	ryland
altimore,	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mantal Hygiena. Important: if Item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exacting Insurance profitted at once.		21. Signature of Funeral Service Lic	ensee			22. Name	end Addr	ess of Facil	ity			-1-0	
m	Depa impo any ir		1 Amilhadan	anh - C	)hi-	_142 1	assah	n_Fune	eral Ho	me, I	nc.			
_			23a. Part 1. Enter tha disease, or co										21236-46	2.11
		ļ.,	shock, or heart failure. List on	ly one cause on e	ech line.	ui. Do not e	mer uie //	/oda or dy	ing, such as	s cerdiac	or respiratory	errest,		Approximate Interval Between
)	Physician		1											Onset end Death
	/Medical Examiner		Immadiate Ceuse (Final disaasa or condition	CARI	DIAC T	AMPO	VADE						i	DAYS
		_	resulting in death)		Due to (	or as a cons	equence o	of):		_				
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o	an a	ŭ	if eny, leading to immediate cause. Enter Underlying										i	
68/60,	ta be	edical	Cause (Disease or injury that initiated events	C	Due to (c	or as e cons	equence o	of):						
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ō	Phys reldi	F-	27. Manner of Death	28a. Dete		ER/Outpeti 28b. Time		DUA	4 L N		me 5 Li Hes 28d. Describe		Other (Speci	Ty)
ב	ding h. After funer	lor	1 Natural 5 ☐ Pending	(Mont	h, Day Year)	Injury	M	28c. Inju	ork? ]Yes 2⊡		200. 2000.20	Thom injury o	70041104	
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Δ	2 1 200	Σ	29b. Signature and title el certifier	0			1	29c. Licen	se nu <i>m</i> ber			29d. Date s	signed (Month,	Dey, Year)
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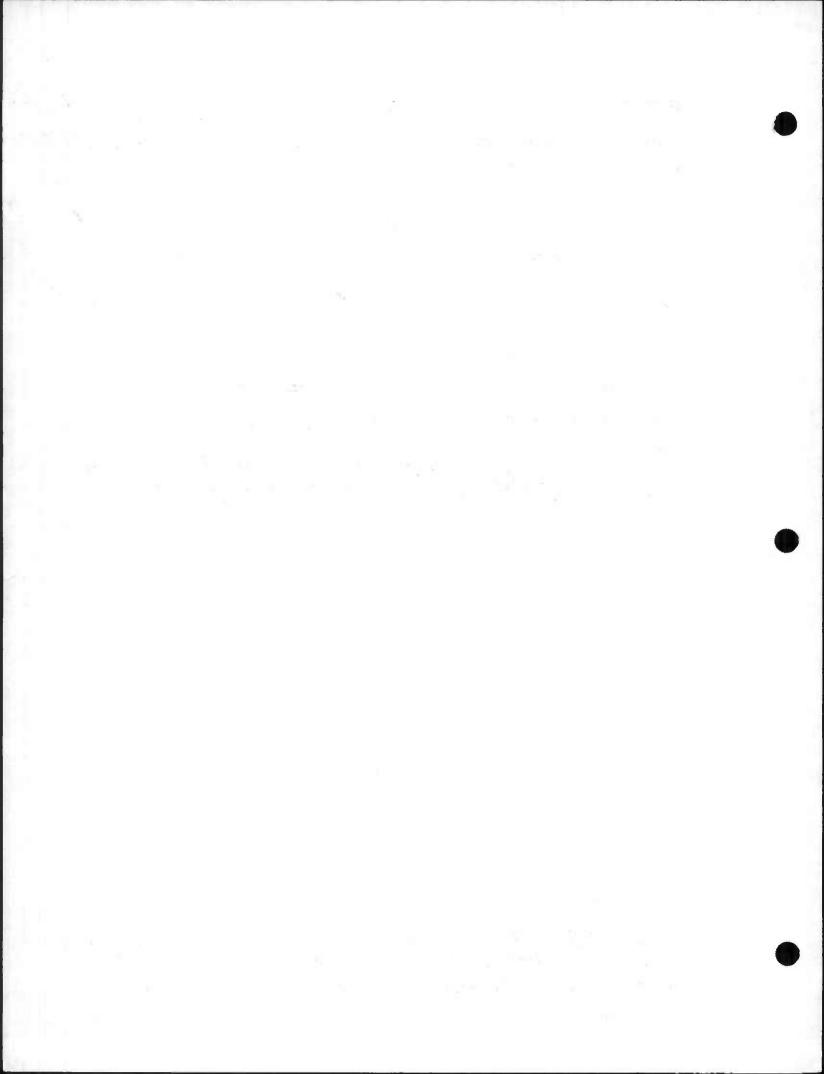
**DHMH 16 Rev 6/95** 

Registrar



				State of Ma		epartment of F Certificate of			eg. No.	1 2	1369
ľ	Physici		Decedant's Nama (First, Middla, Last FRANCES	st)	GII	ERCZAK		2. Data of Deal	th Day	Yaar (997	3. Tima of Death 4:25 An
Y	/Medio Examir		4a. Facility Nama (If not institution, give	a straat and numbar)			4b. City, Town, or Lo		4c. County		
			Stella Maris Nurs	ing Center			Timonium	1	Bal	timor	e
	Funeral Director		5. Social Security Number 6. S 216-07-0620		(In yrs. last birt	hday) If Undar 1 Yaar Months Days	if Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, 6/6/19	Year)		laca (Stata or Foraign
	Mond Mond		Usual Rasidance of Dacedant  10a. Stata 10b. County		10c. City, Town	or Location				10	0d. Inside City Limits
	a-f sh	ctor	MD N/A		Balti	more City					1 Yas 2 □ No
	or 28	Oire	10e. Street and Number			10f. Zip Coda		1	0g. Citizen of \	What Coun	try?
	23a	rai	141 N. Kenwood Av	e.		212	.24		U.S.A.		
020	should be filed within 72 hours after death with the Maryland not Mental Hyglene. I marked other than "natural", or items 23s or 28s-f show urnsitic event, the Medical Examiner must be notitied at	by Funeral Director	11. Marital Status  1 ☐ Nevar Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedant E Armed Forcas? 1 ☐ Yas 2 ☑ N If Yas, Giva Yaar or Datas:	E-00.1	13. Was Decedant of H If Yas, specify Cub 1 ☐ Yas 2 ☑ No	Hispanic Origin? (Spean, Maxican, Puarto Specify:	ecify Yas or No- Rican, atc.)		e - Amarico ck, Whita, a	atc.
2-0	72 ho	ted	15. Decedant's Ed (Specify only highast gra	ucation	16a.	Decedant's Usual Occup (Give kind of work dona	pation	ina	16b. Kind of B		
altimore, Maryland 21215-0020	within ene.	Be Completed	Elamantary/Secondary (0-12) Unk.	Collega (1-4or 5-		iifa. DO NOT use retire. Housewife	d)	ing .	N/A		
ō	Hyg offi-	e C	17. Fathar's Nama (First, Middla, Last)			Hodsewile	18. Mothar's Name	a (First, Middla, M		na)	
lan	lental ked c	To B	Stanislaus Kocien	da			Alheco W				
ary	2 should be filed with end Mental Hygiene, is marked other than aumatic event, the	-	19a. Informant's Name/Ralationship (7	ype, Print)	19b.	Mailing Addrass (Straat		-	, City or Town,	Stata, Zip	Coda)
Σ	1 end 2 Heelth e am 27 is		Joyce Dabrowski/D	aughter	30	2 Valdene C	t. Timoni	um, MD 2	21093		
ore	of He		20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐	Dameuel from State	20b. Place of	Disposition (Nama of r, crematory or othar pla			20c. Location -	City or To	wn, Stata
Ĕ	Peg ment ant: fi		4 □ Donation 5 □ Othar (Specify		Holy R	osary Cemet	ery 7	/17/97 I	Baltimo	re Cn	itv., MD
Ball	permit. Peges 1 and 2 should Department of Heelth end Mer Important: if itam 27 is merke any injury or other traumetic ance.		21. Signature of Funaral Sarvice Lies	Ilma	lest.	22. Nama and Addra B. Dabrows 2818 E. Ba	ss of Facility ki & Son	Funeral			
	Physician / /Medical Examiner	Examiner	23a. Part1. Entar tha disaasa, or comp shock, or haart failura. List only of immediata Causa (Final disaasa or condition rasulting in daath)	a	Oua to (or as a c	CA	Ē 61			75	Interval Between Onset and Death
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Box 68760,	t the deeth cartificete be executed by the attending physicien end teched for use as the buriel-trensit	Physician/Medical	Cause (Disaasa or Injury that initiated evants rasulting In daath) Last	d	lua to (or as a co	onsequance of):					
O. H	deet he att	sici	Part II. Other significant conditions co	entributing to death but	not rasulting in	tha undarlying causa giv	van in Part i.	23b. Did to	bacco uae co	ntribute to	the cause of death?
J.								1 □ Y	98 2□ No	3 Prob	bebly 4 Unknown
Hecords,	i law requires that hes been signed b p 2 should be dete	Completed by						24a. Was a perform	n autopsy ned?	ava	are autopsy findings allable prior to applation of cause death?
	9 - 0	Con						1 □ Ya	as 2.21No	1□	Yas 2□ No
Vital	detant: Th certificate rector, pa	Be	25. Was casa rafarred to medical axaminar?				26. Placa of Daati	h (Check only on	a)		
6	Physician: this certific ral director.	2	1 ☐ Yas 2 No	Hospital:	1	patient 3LI DOA		ma 5 Rasida			Hospice
	Attending P ir death. ector: After t by the funeral	ation:	27. Mannar of Déath 1 Natural 5 ☐ Pending 2 ☐ Accidant invastigation			jury Wor	y at rk? Yas 2 □ No	28d. Dascribe ho	ow Injury occur	red	
DIVIS	al or Atte s after de l Directo od in by th	Certification:	3 Sulcida 6 Could not be datarmIned	28e. Place of Injur building, atc.	ry - At homa, fan (Specify)	m, street, factory, office		28f. Location (St. City or Town		er or Rura	Routa Number,
	ATHOSPH We Funding	Medicai	29a. Certifiar (Check only one) 2 Medical Exam	rsician: To the best of iner: On the basis of a and manner state	examination and	daath occurred at tha tir /or Invastigation, In my o	ma, data and placa, a plinion, daath occurr	and dua to tha ca ed at tha tima, da	ausa(s) and ma ata and place,	annar as stand dua to	ated. tha cause(s)
-	2129	2	29b. Signatura and titla of certifle	11	11	29c. Licans	a number	25	9d. Data signe	d (Month, I	Day, Year)
A	1		30. Name and address of person who		1	ype, Print)	1220	10	01,	117	
	Sta	te	DR. SHIRLEY THOMI 31. Data filed (Month, Day, Year)	32. Registrar	's Signatura		VALLEY RD	. TIMON	IUM, M	210	93
	Registr	ar	JUL 1 5 1997	Julia Davidson	-Randell						

Registrar DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 97

			Certificate of De			. No.	1 4	.1370
	Physic /Medi		1. Decedant's Nama (First, Middla, Last)  EPHRIAM GAINER		eata of Death Month	Day	Yeer 997	3. Tima of Death 4:55 AM
	Exami		SINA I HOSPITAL OF BALTIMORE B  5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year III  Months Days III	City, Town, or Location  ALTIM  f Under 24 Hrs. Hours Min.  (A)		4c. County	of Death	ace (Stata or Foraign
	Director		Usual Rasidance of Decedant		ot.25,			rida
	Marylend R-f show	tor	Maryland Baltimore City Baltimore				10	0d. Insida City Limits 1 ✓ Yes 2 □ No
	23a or 28	Funeral Director	10a. Street and Number 10f. Zip Coda 4301 Hayward Avenue 21215			Citizan of V	Vhet Count	ry?
020	d within 72 hours efter death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at	b	11. Marital Status  1 □ Naver Married  2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U,S. Armed Forcas?  1 □ Yes 2 ☑ No If Yas, Giva Year or Datas:  13. Was Decedant of Hispa If Yas, Specify Cuban, M		ras or No- n, etc.)		e - Amarica k, Whita, a	
21215-0020	70 To be 150	Completed	15. Decedant's Education (Specify only highest greda complated)  Elementery/Secondary (0-12)  12  16a. Dacedant's Usual Occupation (Give kind of work dona durit life. DO NOT use ratired)  **Total College (1-4or 5+)  2  Mail Cler**	ing most of working		b. Kind of Bu Housin		ustry
	2 should be filed with end Mental Hygiene. Is marked other than aumatic event, that	BeC	17. Fathar's Nama (First, Middla, Last)	B. Mother's Nama (Firs				
Maryland	Ment Ment arked	2	unknown	Margaret			Gaine	
Mar	0 0 0		19a. Informant's Name/Ralationship (Type, Print)  19b. Mailing Address (Straat end					,
altimore, I	permit. Peges 1 end 2 should be filed Depertment of Health end Mental Hyg Important: if Iem 27 Is marked othe any Injury or other traumatic event, ODG.		Barbara Gainer/wife  20a. Mathod of Disposition  1 Burial 2 Cramation 3 Ramoval from Stata 4 (Stonation 5 Othar (Specify)	Avenue, Ba		e, Mar c. Location -		
Balti	permit. Peg Depertment Important: i any injury o						Balti	imore Stree
	Physician		23a Fart1. Enter the disease, or complications their caused the death. Do not enter the mode of dying, s inock, or heart failure. List only one cause on each line.					Approximate intervel Batwaan Onsat and Daath
1	/Medical Examiner		Immediate Ceusa (Final disease or condition resulting in death)  a. ACUTE INFERIOR MY(	OCAROLU	MIN	JFARCT	ION	DAY
-	pe tis	iner	CORONARY ARTERY	DISEA	SE			YEARS
60,	Dirigi-tran	ai Examiner	Sequentially list conditions, if any, leading to immadiata cause. Enter Undartying Causa (Disaasa or Injury that initiated avants  Dua to (or as a consequence of):  Dua to (or as a consequence of):  Dua to (or as a consequence of):	ST				DAY
Box 667	eath certificati ettending pro- for use as the	n/Medicai	resulting in death) Last  Due to (or as a consequence of):					
	death	Physician/N	Part ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in	in Part I.	23b. Did toba	ICCO USO COI	ntribute to	the cause of death?
s, P.O	es thet the de igned by the e be deteched t	by Phy	DIABETE MELLITUS		1 🗆 Yes	2□ No	3 Prob	ably 4 Unknown
Vital Records,	aw requires been so should	Completed			24a. Was an a performa	autopsy d?	con	ra autopsy findings vilable prior to nplation of cause death?
E E		Con			1 ☐ Yas	2 No	10	Yas 2 No
Vita	lclan: The certificate rector, pag	Be	axaminer	6. Place of Death (Chi	ack only ona)			
of	Physical direction	2	1 Tas 20 No 1 Dinpatient 2 ER/Outpatient 3 DOA	4□ Nursing Homa	5 ☐ Rasidano Dascribe how			)
Division	To the Hospital or Attending Physician: within 24 hours effer death.  To the Funeral Director: Affer this certific completely filled in by the funeral director.	Certification:	1 Naturel 5 ☐ Pending (Month, Day Year) injury Work? 2 ☐ Accident invastigation 3 ☐ Suicida 6 ☐ Coule mote determined determined	s 2 □ No 28f. L	ocation (Stra	at and Numb		l Routa Number,
Ö	To the Hospital or within 24 hours efter To the Funeral Direction completely filled in		building, etc. (Specify)  29a. Cartifier (Check only)  29 Medical Examiner: On the bast of my knowledge, death occurred at the time, of the bast of axamination and/or investigation. In my online	date end place, and d	ua to tha cau	se(s) and me	ennar as sta	ated.
	the Hin 24 the Fu	fedical	one) and mannar stated.					
	Veit To	Σ	29b. Signature and titla of certifiar  HOUS€ STAFF  29c. Licansa nu		290	. Data signa	d (Month, E	Jay, Year)
			30. Name and address of person who completed causa of daath (Itam 23a) (Type, Print)					1997
			JOHN V. WU, M.D SINAI HOSPITAL  31. Data filed (Month, Day, Year)  9. 32 Ragistrar's Signetura	C OF BA	LTIMOR	EIL	10 -	21215
	Sta Registr		31. Data filed (Month, Day, Year)  JUL 1 5 1997  July 1 5 1997  July 1 5 1997					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2'10 Pm 2. Date of Death **Physician** Month Year ANTHONY HILLARD July 09 /Medical 1997 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street and number) 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY
If Under 24 Hrs. 8. Date of 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 323 · 24 · 3440 Usual Residence of Decedent Yrs. Director OLUSIANNA death with the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 Yes 2 No BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 2 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status parmit. Pages 1 and 2 should be flied within 72 hours after to Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "natural", or fee any injury or other traumatic event 1 ☐ Never Married 2 ☐ Married Specify: BLACK Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No p 3 ☑ Widowed 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highe Elementary/Secondary (0-12) College (1-4or 5+) MOUSINE RIVER PRIEGER TENNED! 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROOSVELT HILLARD UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH BROWN R. Date 5826 SPRING HOLLOW DAUGHTER INTEDO 20c. Location - City or Town, State 20b. Place of Disposition (Name of cametery, crematory ex other place) 20a. Methed of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State GARRISON FOREST UWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licansee 22. Name and Address of VAUGHN C GREENE FUNERAL SERVICE 5151 BALTO. NATL' PIKE 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BALTO 21229 Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) one month Examiner Examiner unknown attanding physician end for use as the burial-trensit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? 1 Tyes 2 XNo 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death uneral 28b. Time of 28d. Describe how injury occurred After Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident setor: 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) end manner es steted.

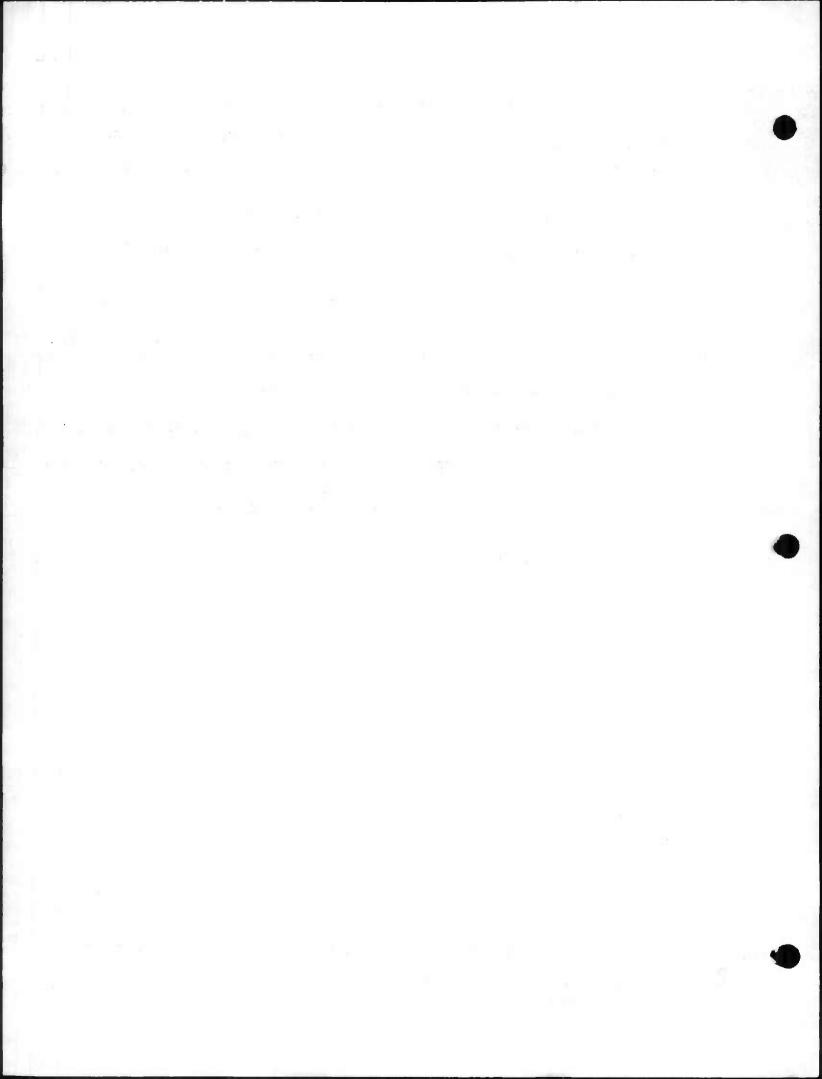
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) anell RES-000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Johns Hopkins Hospital Powell Greg 31. Date filed (Month, Day, Year) State

Registrar

Lg r

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 2 1 3 7 2

						Cen	tificat	e of	Death		Re	eg. No.		
	Physic /Medi	Cecii U. nicks Jr.   liii V li 1007											3. Tima of Death 2;02 p	
	Exami		4e. Fecility Name (If not institution, give 3708 Howard Par		ar)					wn, or Lo ltin	cation of Death	4c. County of	of Death,	a
	Funeral Director			ax 7. XM 2□ F	Aga (In yrs last bir	thday) Yrs.	If Undar Months	1 Year Days		24 Hrs. Min.	8. Data of Birth	<b>34</b> ,193	9 Birthpl 5 Coun	aca (Stata or Foraign Baltimore
	Ba-f show	Director	Usual Residence of Decedent  10a. State  MD  n/a	l	10c. City, Town	n or Loc	ation	Е	BALTI	MORE	Ε		10	Od. tnsida City Limits  XXYas 2□ No
	th with the 23e or 2	al Dire	10e. Straat end Number 3708 HOWARD	PARK	AVE		10f. Zip	Code	2	1207		Og. Citizan of W	hat Count D	STATES
020	d within 72 hours after death with the Maryland plane. I than "natural", or frems 23a or 28a-f show the Madical Examinations the notified at	by Funeral	11. Maritel Status  1 ☐ Never Marriad 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Deceda Armed Force XXYas 2 If Yas, Giva Year or Deta	as? □ No	If	/as Deced Yes, spec □ Yas 2	cify Cub	an, Maxican	, Puarto	ecify Yas or No- Rican, etc.)		- Amarica , Whita, a	
21215-0020	in 72 ho "natur	Completed	15. Decedant's Ed (Specify only highast grad	da com <i>pleted)</i>		(Give k	ant's Usua and of wor ONOT us	rk dona	durina most	t of worki	ng	16b. Kind of Bus		lustry REED
212	within iane.	E	Elamantary/Secondary (0-12)	Collega (1-4			cal		echni	cia	n	MEDI		CENTER
g	e filed al Hygie other	Be C	17. Fathar's Name (First, Middla, Last)								(First, Middle, N			CDIVIDIO
Maryland	should be find Mental I	To B	CECIL U.	HICKS	SR.				В	EUL.	ΛH			
N	2 shou and M is mari	1	19a. tnformant's Name/Ralationship (T			. Mailing	Addrass	(Stree			H II I Routa Number	City or Town.	Stata Zin	Coda)
Baltimore, I	permit. Pages 1 end 2 should be filed Depertment of Health and Mental Hyg Important: If Item 27 Is marked othe any Injury or other traumatic event, ORGs.		JACQUELINE  20a. Mathod of Disposition  XIMBurial 2 Cramation 3 di 4 Donation 5 Other (Specify,  21. Signature of Funeral Service Licens	)	20b. Place of	ISO 22.	ition (Name en March	na of thar pla FORI d Addra	EST V ass of Facilit H We	A sest	7-16-97	20c. Location - 0	City or Tov	wn, State
	Physician /Medical Examiner	Jer .	23a. Part1. Enter tha diseese, or comp shock, or heart failure. List only o Immediata Cause (Final disease or condition rasulting in death)		Dua to (or as a c	To carrica	م بد	e or ayı	ng, such es	cardiac o	r respiretory arre	est,		Approximata the tarval Batwean Onsat and Death
Box 68760,	eath certificate be executed attending physician and for use as the buttal-transit	an/Medical Examine	Sequentially list conditions, if any, leading to immediata causa. Entar Undarlying Causa (Disaase or Injury that Initiated avants rasulting in death) Last	b	Due to (or as a c				- 8					
P.O. B	y the ached	Physician/	Part II. Other etgniftcent conditions co	ntributing to death	n but not resulting in	tha une	darlying c	ausa gi	ven in Pert I.			bacco uaa con		the cause of death?
Records,	v requires been sign should be	Completed by	70 ( 20 : 10   13 : 12								24a. Was a	n autopsy ned?	con	ore eutopsy findings alleble prior to applation of cause death?
=	ician: The lav certificate has rector, page 2	Con									1□ Ye	s 2 No	1	Yas 2□ No
/ita	cian: setific ector,	Be	25. Was casa rafarrad to medical axaminer?						26. Place	of Death	(Check only on	a)		
of Vital	2 40	To	1 Yes 2 No	Hospital: 1 ☐ Inpe	atiant 2 ER/Out	tpatiant	3□ DO	A Otl	har: 4□ Nu	rsing Hor	ne 5 Rasida	nca 6 □Otha	r (Specify	)
Division	or Attending ifter death. Niractor: After in by the tune	Certification:	27. Menns of Death Naturel 2 Accident 3 Suicide 4 Homicide  2 Homicide 3 Could not be determined	28e. Placa of		ima of njury rm, stre	М		ryet rk? ]Yas 2⊡I	No	28d. Describe ho 28f. Location (St. City or Town	reet and Numbe		Routa Number,
-	Pospital (24 hours a Funeral C letely filled	edical Co	29a. Cartifiar (Check only one)	sician: To the be Inar: On the basis and mannar	st of my knowledge, of examination and stated.	, daath d d/or inva	occurred a	at the ti	me, data an opinion, daa	d place, a	and dua to tha ca ad at tha tima, da	ausa(s) and mar ata and place, a	nnar as sta nd dua to	ated. tha causa(s)
1	To the	Me	29b. Signatura and itle of certifier				290	. Licen:	se number			9d. Data signet	(Month,	Day, Yaar)
-	JA	1	160	my	m.D.			D	3 4.	508	5	7/	14	57
1	- W	(,	30. Nama and address of person who co		of death (Item 23e) ( っしてん			املا	B	ALT	lmonk	mo	2	1207
	Sta Registi		31. Date filad With, Pay 5 1997	32 fine	treris 6ignatura	Pande	e.							

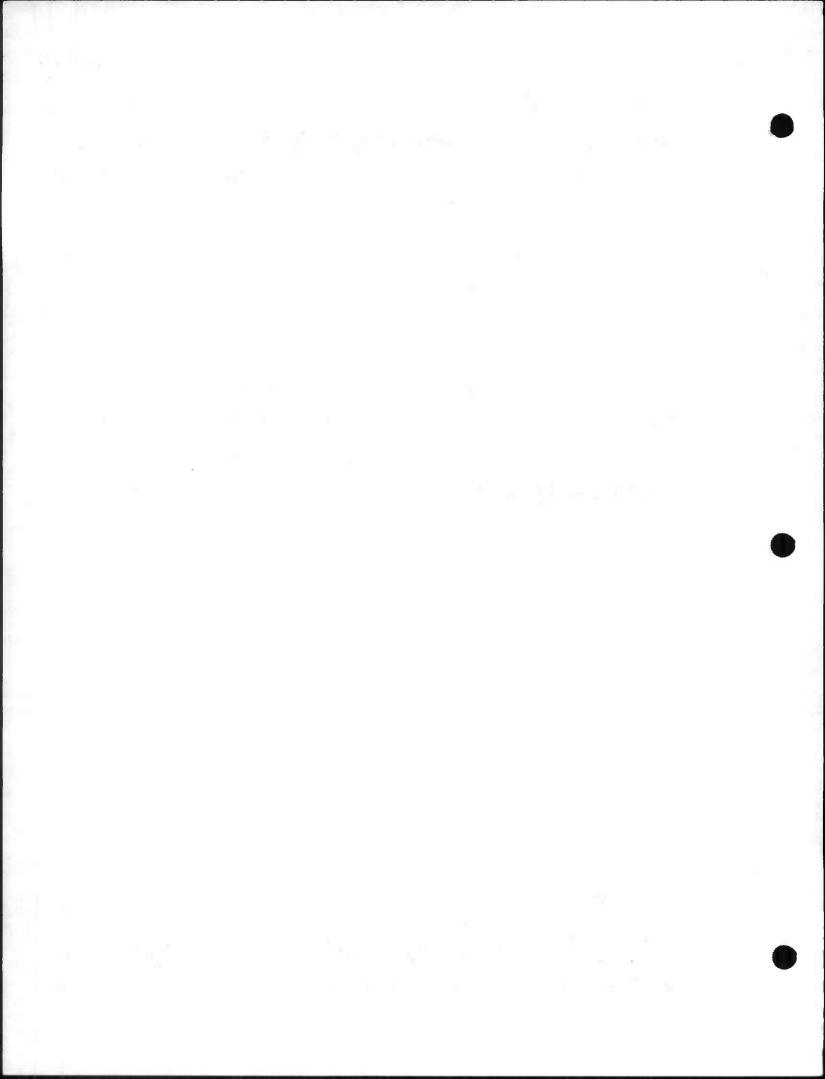


# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97

						Cen	tificate of	Death		Reg. No.	, ,	21010
r	Physic	ion	1. Decedent's Name (First, Middle, La	ast)					2. Dete of De Month	eth Day	Year	3. Time of Deeth
	/Medi		MELVIN	FRANCIS	H	OLLA	ND		July		997	4:10 PM
	Exami		4e. Fecility Neme (If not institution, gir	ve street and number)				4b. City, Town, or	Location of Deetl	4c. County	of Deeth	
$\mathbb{L}$			3907 Hannon Ct.					Perry H			Balti	more
	Funeral Director			1TXM 2TTE	(In yrs. last bi	rthday) Yrs.	. If Under 1 Year Months Deys	Hours Min	8. Date of Bir (Month, Da Apr. 11	y, Year)	9. Birth	place (State or Foreign ntry) Md •
	Pud Man		10a. State 10b. County		10c. City, Tov	vn or Loc	alion					10d. Inside City Limits
	the Mery 28a-f sh	Funeral Director	Md. Baltin	more	P	erry	Hall 10f. Zip Code			40- 05		1 ☐ Yes 2 🛣 No
	with the or	ā		T-4- 33				200		10g. Citizen of \		ntry r
	eath re 23	era	3907 Hannon Ct.	12. Wes Decedent E	ver in I1 S	13 W		236 Hispanic Origin? /9	nacify Vac or No		USA	can Indian.
21215-0020	be filed within 72 hours efter death with the Meryland stall Hygiene.  Id other than "natural", or Items 23s or 28s-f show event, the Medical Exerciter must be notified at	b	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 ☑ Yes 2 □ N  If Yes, Give  Year or Dates:	lo		Yes, specify Cub	Hispenic Origin? (S pan, Mexicen, Puer Specify:	to Rican, etc.)	Black Specify	ck, White,	
2-0	2 ho	Completed	15. Decedent's E	ducetion		Decede	ent's Usuel Occu	petion		16b. Kind of B		
21	within 7 ene. than "n	pie	(Specify only highest gr. Elementary/Secondary (0-12)	ade completed)  College (1-4or 5-	+)	life. D	ond of work done O NOT use retire	during most of wo	rking			
2	giene giene	5	12			ales	Man			Church :	Hill	Distributo
pu	al Hy al Hy roth	Be	17. Fether's Neme (First, Middle, Last	)				18. Mother's Na	me (First, Middle,	Maiden Suman	ne)	
Maryland	12 should be filed within n end Mental Hygiene. is marked other than " raumatic event, the Me.	2	Melvin	F	Hollar	nd		Elizabe	th		K€	ershaw
ar	2 sho end is me		19a. Informent's Neme/Relationship	Type, Print)	191	o. Mailing	Address (Stree	t and Number or R	ıral Route Numb	er, City or Town,	State, Zip	Code)
	5 = 2 r		Mrs. Emma Holland	d/wife	3	907	Hannon (	Ct. Unit	lA Perry	Hall,	Md.	21236
altimore,	Pages 1 a nent of Hea nt: if item		20a. Method of Disposition  1 ☐ Burial 2 🖾 Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci		cemete	ry, crem	ition (Name of atory or other pla ervice (		Date 7/14/97	20c. Location -		
Balti	permit. Pages 'Depertment of Limportant: if ite any injury or ot once.		21. Signature of Eugeral Service Lite	Dog.		22. Ru	Name end Addr Ck TOWS	ess of Fecility on Funera	1 Home,	Inc.		
1	_		23a. Part1. Enter the disease, or com shock, or heert failure. List only	plications that caused	the deeth. Do			Rd. TOWS				Approximale
V	Physician /Medical		immediate Ceuse (Final		,				,			Interval Between Onset end Death
1	Examiner		diseese or condition resulting in death)	a	~ / (.	1	Met	ravetis				. C Ms
		ē		'	Due to (or es e	consequ	ence ot):	. 1			i	2
	cate be executed physicien end s the buriel-transit	Examiner	Soquentially list conditions		Due to (or es e			6/44			1-	242
ó	exec an en riel-tr		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	•	340 10 101 03 0	CONSUQU	01100 01).					
68760,	ysicie	Ca	that initieted events	C	Due to (or es e	consequ	ence of):				-	
Вох 68	death certificate be executed e ettending physicien end of for use es the buriel-transit	n/Medical	resulting in death) Lest	d								
	death e ette d for	Physician/	Pert II. Other significant conditions of	contributing to death bu	t not resulting i	in the un	deriving cause gi	ivon in Port i	22h Bid	lohecco upo co	ntelbuto t	o the cause of death?
P.0	by the de	hys			Chornesumg i	ii tiio uii	deliying cause gi	Voli III Foit i.			_	bably 4 Unknown
	es thet igned t	by P	- Ame pletes	trace						100	0_,,,0	Dabi, 4 Olikiowii
Division of Vital Records,	requir been s should	Completed t							24e. Wes perfo	an autopsy rmed?	ev	Vere eutopsy findings velleble prior to ompletion of ceuse deeth?
ď	The law ate has page 2	E							10	Yes 20 No	1[	□Yes 2□No
ita	Iclan: The	Bec	25. Wes case referred to medical					26. Place of De	ath (Check only o	nne)		
f <	D S	2	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatier	nt 2 ER/O	utpetient	3□ DOA Ot	her: 4 Nursing H	lome 5 - Resid	ence 6 Oth	ier (Specil	fy)
0 6	6 7	on:	27. Manner of Death	28e. Date of Injury (Month, Day	y 28b.	Time of	28c. Inju Wo			now injury occur		
0	THE !	atio	1 ☐Naturel 5 ☐ Pending 2 ☐ Accident investigatio		, ear)	injury		Yes 2 □ No				
Divis	i or After effecte Directo d in or if	Certificati	3 Suicide 6 Could not be determined		ry - At home, fa (Specify)	arm, stre	et, factory, office		28f. Location (: City or Tox		per or Rura	al Route Number,
	To the Hospital or A within 24 hours effect To the Funeral Director Completely filled in	edical C	29a. Certifier 1 CertifyIng Pt (Check only one) 2 Medical Exam	nysicien: To the best of niner: On the basis of end menner stat	examination ar	e, deeth o	occurred et the ti estigation, in my	me, date end plece opinion, death occu	, end due to the rred et the time,	ceuse(s) end ma dete end place,	anner es s end due t	tated. o the cause(s)
	Vithir To th	Me	29b. Signature and title of certifier				29c. Licen	se number		29d. Dete signe	d (Month,	Day, Year)
	. > - 0		10-	Aun	-		2	lanc :		7/	146	9.0
	1:00		30. Name and eddress of person who	completed cause of de	ath (Item 23a)	(Type P		10091		, , ,	/ (	
	Ju.		A Man A	Scraille	مد م	√.		d N.	e Cara	Tar	10.	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registre	r's Signeture		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		-	, , ,	Br ton	neg
	Registi		JUL 1 5 1997	Jake Durds	n1 12. 1	20						
				U	- Indam	-						

State of Maryland / Department of Health and Mental Hygiene 97 2 1 3 7 4

						Certifica	ate of	Death		Reg. No.	Euro	1074
	Physici /Medio		1. Decedant's Name (First, Middla, Last	HESS					2. Data of Da Menth	Day	Year 997	3. Tima of Deeth
	Examir	er	49, Fecility Neme (If not institution, giva	street end number)	CHARICE	sst. 1.	Balt.	Ba H	Location of Death		6 .	DORE
	Funeral Director	14	5. Sociel Security Number 6. Sec		'In yrs. last birti		ler 1 Year	il Under 24 Hr. Hours Mir		Peri	9. Birthple	aca (Stata or Foreign rly) V York
	e Merylend ta-f show tifted at	ctor	10a. Stata 10b. County Maryland N/A	1	Oc. City, Town		altin	more			10	od. inside City Limits 1 X Yes 2 □ No
	th with th 23e or 28	rai Director	10e. Street end Number 111 Hamlet Hi	ill Road		10f. 2	Zip Coda 212	210		10g. Citizan of W	/het Count USA	ry?
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylend Deperment of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, its Medical Examiner must be inclined at page.	by Funeral	11. Marital Status  1 □ Never Merried 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ev. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yeer or Detas:	er in U,S.		cedent of H becify Cube 2 No	lispenic Origin? ( en, Maxican, Pue Specify:	Specify Yas or No rto Rican, atc.)	14. Rece Black Specify:	e - Amarica k, White, e	
15-0	n 72 h	Be Completed	15. Decedant's Edu (Spacify only highest grad	cation a <i>completed</i> )	18a.	Decedant's Us	sual Occup	ation during most of we	orking	16b. Kind of Bu	siness/Ind	ustry
212	d withingiene.	ошо	Elamantary/Secondary (0-12)	College (1-4or 5+)		Teacl		,,		Tap D	ance	2
and	be file tal Hy d othe event,	Be C	17. Fathar's Nama (First, Middla, Last) William Marti	in Broun					uma (First, Middla, G. Vee		э)	
aryla	should nd Mer marke	10	19a. fnformant's Name/Relationship (Ty		19b.	Mailing Addre	ess (Street		Rural Routa Number		Stata, Zip	Code)
	and 2 salth e n 27 is		Carol Hess-Vait		r 225	N. Be	aumon	it Avenue	e Catons	sville,	MD 21	.228
altimore,	: Pages 1 tment of He tant: If Iten		20a. Mathod ol Disposition  1 □ Burial 2 ☼ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)		20b. Place of comatan Metro	cramatory o Cremat	ory,	Inc.	Data 7/14/97		more	e, MD
Bal	Depermit Important Importa		21. Signature of Funerel Service London  Dawn F. McDo	Manald onard		Crema 299	end Addre ation Frede	ss of Secility 1 Socie erick R	ty of B	Marylan altimor	d, I	Inc. MD 21228
	Dhamining		23a. Pert1. Entar tha diseese, or compi shock, or heart failura. List only or	ications thet caused the na causa on each lina.	e deeth. Do n	ot enter the m	ode ol dyln	g, such as cardla	ac or raspiratory a	rrast,		Approximata intarval Between Onsat and Death
	Physician /Medical		Immediata Ceuse (Finel disaasa or condition	metast	atic 1	Breas	+ Cm	UCEY				2 months
8	Examiner	_	rasulting in daath)		ua to (or as a c			-1001				~ morning
	d d ansit	Examiner		)			1).					
ó,	iceta be executed physician and s the buriel-transit	Еха	Sequantially list conditions, if eny, laading to immadiate causa. Enter Underlying Causa (Disaasa or Injury		ua to (or as a c	onsequance o	1):					
68760,	iceta b physic s the b	Medical	that initiated avants resulting in death) Last	Du	e to (or es a co	onsequence o	f):					
Box (	eath certifice ettending ph for use es t		L,	d								
	that the death ce ed by the ettendi detached for use	Physician/	Part II. Other significant conditions cor	tributing to death but i	not resulting in	tha undarlying	g causa giv	en in Part I.	23b. Dld	tobacco use con	tribute to	the cause of death?
P.0	that the	/ Phy	rectal como	er					10	Yes 24 No	3 Prob	ably 4 Unknown
of Vital Records,	Physician: The lew requires that the death cartificate be executed that certificate has been signed by the ettending physician and infector, page 2 should be detached for use as the buriel-transit	Completed by							24a. Was	en eutopsy rmed?	ava con	ra eutopsy lindings illabla prior to appletion of cause death?
E B	The lev	Com							10	Yas 2 No	1 🗆	lYes 2□No
Vita	yetclen: The la s certificate he director, page	Be	25. Was case refarred to medical axaminar?	lospital:			Oth Oth	00	eath (Check only o			11.
6	nding Physics Str. F. Aher this is funeral d	ation: To	1 Yas 2 No  27. Mannar of Death 1 Natural 5 Pending 2 Accident invastigation	28a. Data ol Injury (Month, Day Y	2 ER/Out 28b. T		28c. fnjur Wor	4 Li Nuising	Home 5 Rask	dence 6 VOthe how Injury occurre	ar (Specity, ed	Hospice
Plvis	Dieg	Certification:	3 ☐ Suicida 6 ☐ Could not be datarmined	28e. Place of Injury building, etc. (	- At homa, lan Specify)	m, street, fact	ory, office		28f. Location ( City or Tou	Street and Number vn, Stata)	er or Rural	Routa Number,
1	the foods hin 2-pote the Func npietely IIII	edicai	29a. Certifier (Check only one) 1 Certifying Phys	efcian: To the best of nor: On the basis of ax and manner state	camination and	daath occurre /or investigation	ed at the tin on, in my o	na, data and place pinion, daath occ	e, and dua to tha surred at tha tima,	causa(s) and mai data and place, e	nner as sta and dua to	ated. tha cause(s)
	To the within To the comple	Σ	29b. Signature and title of certilles	11	1772		9c. Licens			29d. Dete signed		
		-	y / Mhon	ykeley	1 mg		IN	05		July 1	<del>کر / '</del>	17/
2			30. Namé and address of person who ed	mplated caused at	tn (Itam 23a) (1 BMC	Type, Print) 6701	N.	Charles	St. Bal	Cto. Me	1 21	204
	Sta Registr		31. Data light (Month, Payar	788000000	Signatur	delle						



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97

21375

Physician /Medical Examiner  Pansy Helen Hyry  4e. Fecility Neme (If not institution, give street end number) 123 Academy Street  S. Social Security Number 474-03-0255  1 M 27 F 81 Yrs.  Pansy Helen Hyry  4b. City, Town, or Location of Death Annapolis Annapolis  S. Date of Birth Year Months Deys Hours Min. NOV 28, 1915  Month 10, Day 7 Yeer 11:30 AM  4c. County of Deeth Annapolis  Anna Polis  S. Date of Birth Year Months Deys Hours Min. NOV 28, 1915  Month 10, Day 7 Yeer 11:30 AM  4c. County of Deeth Annapolis  Annapolis  S. Date of Birth Year Months Deys Hours Min. NOV 28, 1915  Months Deys Hours Min. NOV 28, 1915  Months Deys Hours Min. NOV 28, 1915  Months Deys Hours Min. NOV 28, 1915  Months Deys Hours Min. NOV 28, 1915  Months Deys Hours Min. NOV 28, 1915  Months Deys Hours Min. NOV 28, 1915  Months Deys Hours Min. NOV 28, 1915  Months Deys Hours Min. NOV 28, 1915  Months Deys Hours Min. NOV 28, 1915  Months Deys Hours Min. NOV 28, 1915  Months Deys Hours Min. NOV 28, 1915  Months Deys Hours Min. NOV 28, 1915  Months Deys Hours Min. NOV 28, 1915  Months Deys Hours Min. NOV 28, 1915  Months Deys Hours Min. NOV 28, 1915  Months Deys Hours Min. NOV 28, 1915  Months Deys Hours Min. NOV 28, 1915	of Health and Mental Hygiene.  Item 27 is marked other than "natural", or items 23s or 28s-f show  other traumatic event, the Maddal Evant her must be notified at  other traumatic event, the Maddal Evant her must be notified at  To Be Completed by Funeral Director	4e. Fecility Neme (If not institution, 123 Academy S  5. Social Security Number 474-03-0255  Usual Residence of Decedent 10a. State 10b. County MD Anne  10e. Street and Number 123 Academy S  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest of Security only highest of Security Secundary (0-12)  17. Fether's Name (First, Middle, Le John Eph 19a. Informent's Name/Relationship Suzanne B. Butti	ansy Helen give street end number) treet  Sex 1 M 2 F 7. Age (i) 8  Arundel  treet  12. Was Decedent Eve Armed Forces? 1 M 2 F 8  College (1-4or 5+) 1  st) ram Wiinam	In yrs. last birthda  1 Yrs.  Oc. City, Town or Anna I  or in U,S. 13	Months Deys  Location DOlis  10f. Zip Code 214  8. Was Decedent of If Yes, specify Cu 1 Yes 2 XNo  cedent's Usual Occur we kind of work done DONOT use retin	Annapol r If Under 24 Hrs. s Hours Min.  O1 Hispanic Origin? (Speen, Mexican, Puerto) Specify:	Month JULY 10 ocation of Death Lis 8. Date of Birth Month, Dath NOV 28	4c. County Anne Anne 10g. Citizen of V USA 14. Race Blace Specify	of Deeth Aru: 9. Birthp M1.  1  Whet Cour e - Americ k, White,	olace (State or Foreigning) INPOSOTA  10d. Inside City Limits 140 Yes 2 No
## Facility Number   According to Street	of Health and Mental Hygiene.  Item 27 is marked other than "natural", or items 23s or 28s-f show  other traumatic event, the Maddal Evant her must be notified at  other traumatic event, the Maddal Evant her must be notified at  To Be Completed by Funeral Director	4e. Fecility Neme (If not institution, g. 123 Academy S. 123 Academy S. 5. Social Security Number 474-03-0255  Usual Residence of Decedent 10a. State 10b. County MD Anne  10e. Street and Number 123 Academy S. 11. Marital Status 1 Never Married 2 Married 3 Never Married 2 Married (Specify only highest g. Elementary/Secondary (0-12) 17. Fether's Name (First, Middle, Le John Eph 19a. Informent's Name/Relationship Suzanne B. Butti 20a. Method of Disposition	Arundel  12. Was Decedent Eve Armed Forces?  1 Wes 2 No If Yes, Give Year or Dates:  Education grede completed)  College (1-4or 5+)  1st)  ram Wiinam.	In yrs. last birthda  1 Yrs.  Oc. City, Town or Anna I  or in U,S. 13	Months Deys  Location DOlis  10f. Zip Code 214  8. Was Decedent of If Yes, specify Cu 1 Yes 2 XNo  cedent's Usual Occur we kind of work done DONOT use retin	Annapol r If Under 24 Hrs. s Hours Min.  O1 Hispanic Origin? (Speen, Mexican, Puerto) Specify:	accition of Death I S  8. Date of Birli NOV 20  Decify Yes or No-Pican, etc.)	Ac. County Anne Anne Year 1915  10g. Citizen of V USA  14. Race Blace Specify	of Deeth Aru: 9. Birthp M1.  1  Whet Cour e - Americ k, White,	nde 1  place (State or Foreigntry)  nnesota  lod. Inside City Limit:  142 Yes 2 Nontry?  can Indian, etc.
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Contract of Section   Contract of Section		20a. Method of Disposition		19b. Ma	iling Address (Stree	at and Number or Rui	ral Route Numbe	r, City or Town,	Stete, Zip	Code)
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23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, inches the death of the death o	De Sur Sur Sur Sur Sur Sur Sur Sur Sur Sur	21. Signeture of Funeral Service bic	Mc Omula	0	22. Name, end Addr CEMATION	Society o	f Maryla	and, Inc	2.	
Medical addresses or condition resulting in death)  Due to (or es e consequence of):  Due to (or es e conseq		23a. Part1. Enter the disease, or co	mplications thet caused the						1220	Approximete
Course (Disease or injury) That inflited events resulting in deeth) Last  Due to (or es e consequence of):	caminer টু	disease or condition	0.			t cencer	•			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.    Part II. Other significant conditions contribute to the cause of death   1   Yes   2   No   3   Probably   4   Unknown	siclan and e bunel-tran	that initieted events	c							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.    23b. Did tobecco use contribute to the cause of death   1   1   1   1   1   1   1   1   1	nding phy use as the	resulting In deeth) Last	■ d	to (or es e conse	equence or):					
24a. Was en eutopsy finding: evalleble prior to completion of cause of deeth?  25. Was case referred to medical examiner?  1   Yes   2   No	ed for	Part II. Other significant conditions	contributing to death but n	ot resulting in the	underlying cause g	iven in Pert I.	23b. Dld to	obecco use con	ntribute to	the cause of death
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29c. License number  29d. Date signed (Month, Dey, Yeer)  D44465  O71097	Funer Funer stely fill	(Check only  Medicat Exa	miner: On the besis of exa	aminetion end/or I	eth occurred et the to nvestigation, In my	ime, date end plece, oplnion, death occur	end due to the cred et the time, d	euse(s) end mei lete end place, e	nner es st end due to	eted. the cause(s)
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		20 Name and address of		(14	1	7-1-10		/	1	-7
	State Registrar	31. Date filed (Month, Day, Year)	File Day	Managur Dank	90.	,				

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death		Reg. No.	21376
Physicia /Medica		1. Decedent's Name (First, Middle, Last)  Mary  Hermbach	2. Dete of De Month	Day Ye	ar 600 PM
Examine Funeral Director	er	4a. Fecility Neme (If not institution, give street end numbar)  4b. City, Town, or Lot		170WC	
the Maryland 28a-f show	tor	Usuel Residence of Decedent  10e. State 10b. County 10c. City, Town or Location Catonsville			10d. Inside City Limits
ath with the 23s or 28s	ral Director	10e. Street end Number 10f. Zip Coda 2207 Rockwell Avenue 21228		10g. Citizen of What	Country?
72 hours after death with the Maryla "netural", or Items 23s or 28s-f show adjest Examiner must be notified at	by Funeral	11. Marital Status  1 □ Navar Married 2 □ Married  3 □ Widowed 4 ⋈ Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puarto for Yeer or Dates:  13. Was Decedent of Hispenic Origin? (Spe If Yes, specify Cuban, Mexican, Puarto for Yeer or Dates:	ocify Yas or No Rican, etc.)		marican Indien, /hita, atc. White
within 72 ho ene. than "netur	Completed by	15. Decedent's Education (Specify only highast grade completed)  Elementery/Secondary (0-12) 12  16e. Decedent's Usual Occupetion (Give kind of work done during most of working) (Give kind of work done during most of working) (Ife. DO NOT use retired)  Systems Analysist	ng	16b. Kind of Busine	
Merital Merital arrived o	To Be Co	17. Fether's Neme (First, Middla, Last)  Edward Rutledge  18. Mothar's Name  Jessie C	Conne	, Maiden Surneme)	
s 1 and 2 sho 7 Hestith and from 27 is m other traum		19e. Informent's Neme/Relationship (Type, Print)  Priscilla J. Atwater/daughter  19b. Meiling Address (Street end Number or Rura 134 Sanford Avenue, Ba	altimor	e, Mryland	1 21228
Page ment o ant: If i		20e. Method of Disposition (Neme of cemetery, cremetory or other place)  20b. Plece of Disposition (Neme of cemetery, cremetory or other place)  20c. Plece of Disposition (Neme of cemetery, cremetory or other place)	Dete	20c. Location - City	
Depart Depart Import any Inj any Inj		21. Signature of Funeral Service Liberage Ronald S. Wade, Director State Anatomy Boar Baltimore, Marylan	nd 2120	1	
Physician /Medical Examiner		Part1. Enter tha disease, or complications thet causad tha daath. Do not anter the mode of dylng, such as cerdiac or nock, or heart feilure. List only one ceuse on each line.  Immediate Cause (Finel disease or condition resulting in deeth)  e	r respiretory e	rrest,	Approximete Intervel Between Onset end Death
	i Examiner	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury c.			
C 0.4	8	thet initiated events resulting in death) Lest  Due to (or es e consequence of):			
requires thet the death cer seen signed by the ettendin should be deteched for use	by Physician/M	Pert ff. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.  Respiratory  For MV  C	23b. Did		ute to the cause of death
e law requires thet hes been signed t ge 2 should be det	Completed D			an eutopsy 24 ormed?	b. Were autopsy findings eveileble prior to completion of cause of death?
certificate he		25. Wes case referred to medical examiner? 26. Place of Death	1 Check only		1□ Yes 2th No
ath. r: After this e funeral di	2	27. Manner of Death This indicates the properties of the propertie		dence 6 □Other (S how Injury occurred	Specify)
Ital or At irs efter of rei Direct lled in by	_	building, etc. (Specify)  29a. Certifier  18ccertifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, etc.	City or To	wn, Stete) cause(s) end menner	Rurel Route Number, es steted.
To the Hosp within 24 hou To the Fune completely fil		(Check only one)  2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurre and manner stated.  29b. Signature and title of certifier  29c. Licensa number	d et the time,	dete end place, and of	dua to the ceuse(s)
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Gary KGZ OW 10805 Hickory Ridge Rd Colours 19	an o	Jul 1	(198)
State Registrar	9	31. Dete iffed (Month, Dey, Year)  11 5 1007  Supering Su	via	CIVIT	

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VALENTINE	State of Maryland / Department of Health and Mental Hygiene	97	2	13	7
HAWRYLENKO Items:23a pa	State of Maryland / Department of Health and Mental Hygiene rt I,27,28a-f per MEO Certificate of Death		-		

**Physician** /Medical Examiner

**Funeral** 

Director

28a-f show must be notified at

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Items 23s

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filed within 7 Hygiene.

.. Pages 1 and 2 should be filed w tment of Health and Mental Hygier tant: If Item 27 is marked other th jury or other traumatic event, In-

permit. Page Department of Important: If eny Injury or once.

**Physician** /Medical

Examiner

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Certification:

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death

72 hours efter

Baltimore, Maryland 21215-0020

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Deeth Valentin Hawrylenko JULY 1997 1 1 9:04A.M. 4e. Fecility Neme (If not institution, give street and number)

JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE

4b. City, Town, or Location of Death 4c. County of Deeth NA

7. Age (In yrs. last birthday) 1√2 M 2□ F 217-52-53333

NA

If Under 1 Year | If Under 24 Hrs. Birthplace (Stete or Foreign Country) Days

Usuel Residence of Decedent 10a. State

47 Yrs March 12 50 Germany 10b. County

1 ☐ Yes 2 No Specify:

10f. Zip Code

Maryland

10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Baltimore

10e. Street end Number

1235 Broening Highway

21224 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

U.S.A. 14. Race - American Indien, Bleck, White, etc.

10g. Citizen of Whet Country?

1 Never Married 2 ☐ Married 3 Widowed Divorced

College (1-4or 5+)

NA

Specify: White 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) 12

Machinst

Yeast Factory 18. Mother's Name (First, Middle, Maiden Surname)

17. Father's Name (First, Middle, Last) George

Hawrylenko

Maria

Kozachok

21224

Approximete Interval Between Onset end Death

19a. Informent's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1235 Broening Highway Balto., Md. 21224

Maria Hawrylenko (Mother) 20e. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State

20b. Place of Disposition (Neme of cemetery, crematory or other plece)

20c. Location - City or Town, Stete

4 ☐ Donetion 5 ☐ Other (Specify)

Oak Lawn

July East Point, Maryland 14 22. Name end Address of Fecility

W. Dabrowski/Chojnacki F.H. P.A. Dundalk Ave. Baltimore, Md. 2122 1005 fler the disease, or complications that faused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, heart failure. List only one cause of each line.

Immediete Ceuse (Final disease or condition resulting in death)

NARCOTIC INTOXICATION

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest

Due to (or es e consequence of):

Due to (or es e consequence of)

200.	Dia	LODGCCO	u
	10	Yes 2	

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown

24e. Was en eutopsy performed?

24b. Were eutopsy findings eveilable prior to completion of cause

1 Nes 2 No

26. Plece of Death (Check only one)

1√Yes 2□ No

25. Was case referred to medical XX es 2 No

27. Manner of Death

1 Naturel

2 Accident

3 Suicide

4 Homicide

Hospital: 1 ☐ Inpetient 2XXX R/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 5 Pending investigation

residence

Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I.

28b. Time of

28c. Injury et Work? 1 ☐ Yes 2√√X No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

found:7/11/97 Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

found:8:20

unknown 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 1235 Broening Highway, Baltimore, Maryland

29a. Certifier

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end manner as stated.

\*\*Difference of the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end manner stated.

\*\*On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated.

29b. Signature end title of certifier Milyonte

JUL 1 5 1997

29c. License number O.C.M.E.

JULY 12,1997

29d. Date signed (Month, Dev. Yeer)

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

MARCHAIA A. KORELL IMP 31. Date filed (Month, Day, Year)

6XXCould not be determined

111 Penn Street, Baltimore, Maryland 21201

State Registrar

32. Registrar's Signeture wha Dirdon

**DHMH 16 Rev 6/95** 

The law requires that the death certificate be executed Box 68760 P.O. | Records, Division of Vital Hospital or Attending Physicien: 24 hours efter deeth. To the Hospital or Attendir within 24 hours efter deeth.

To the Funeral Director; At completely filled in by the fu

State of Maryland / Department of Health and Mental Hygiene

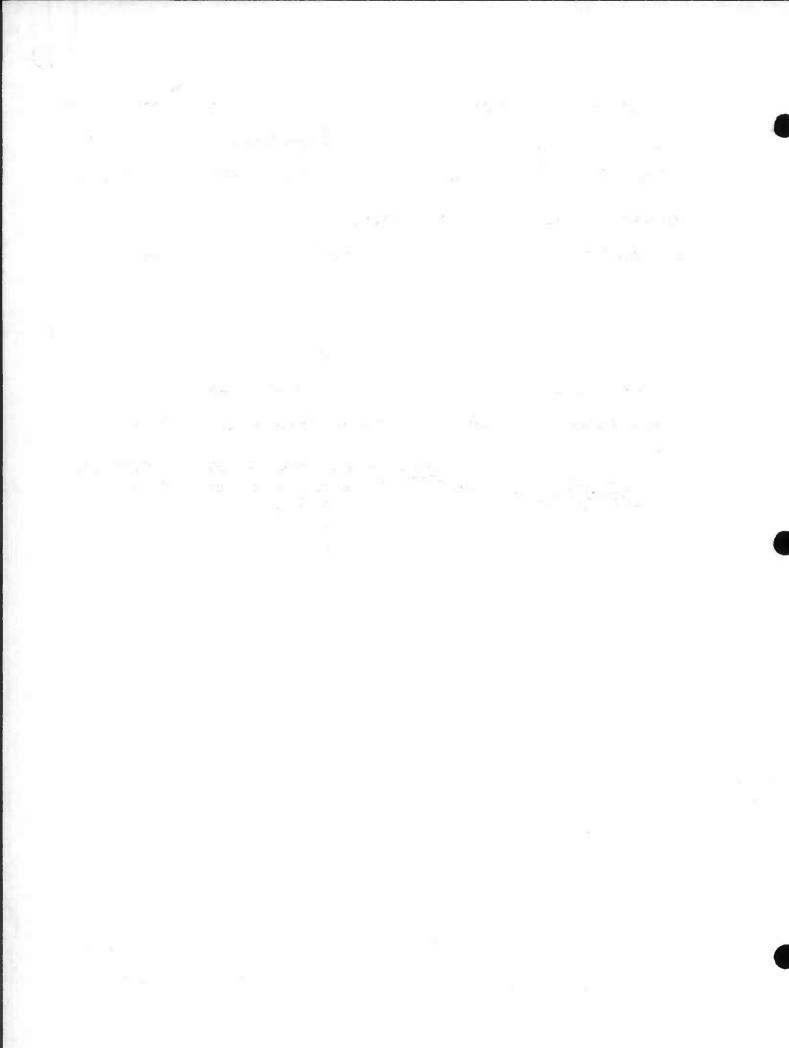
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 1997 **Physician** Mazie D. Johnson July 11:40 PM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 9501 Belair Road Baltimore Baltimore H Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year)

Dec. 9, 1905 If Under 1 Year Months Deys 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplace (Stete or Foreign Country) **Funeral** Months 10 M 20 F 217-05-9499 91 Yrs Maryland Director Usual Residence of Decedent with the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show tem 27 is marked other than "natural", or items 23e or 28e-f sho other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Baltimore Baltimore Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 9501 Belair Road 21236 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Detes: 14. Rece - American Indien, Bleck, White, etc. "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, spacify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus permit. Pages 1 end 2 should be filed within 72 hours after bepartment of Health and Mantel Hygiena. Important: if Item 27 is marked other than "natural", or iteleny or other traumatic event, are Mexical Examinate once. 1 Never Married 2 Merried 3altimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 X No Specify: by 3 XWidowed 4 ☐ Divorcad Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Seamstress Clothing Manufacturer 9th grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Frank King Annie Doan 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 9501 Belair Road, Baltimore, MD 21236 Lorraine Johnson (daughter) 20a. Method of Disposition
1 Disposition 3 Removal from Stete 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State Loudon Park Cemetery 7/12/97 Baltimore. Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Fur Service Licensee 22. Name end Address of Fecility
Schimunek Funeral Homes, Inc. 9705 Belair Road, Baltimore, MD 21236 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediete Ceuse (Final diseese or condition resulting in death) DEMENTIA, ALZINGINER TYPE Examiner Due to (or es e consequence of) Physician/Medical Examiner attending physician end for use as the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Box 68760. Due to (or es e consequença of): SBS P.O. Part II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 200 3 Probably 4 Unknown USTEONOUSIS, SENACE Division of Vital Records, by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed DECUSIONS ULCER 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Desidence 6 Other (Specify) P 1 ☐ Yes 2 🗷 🛪 🖰 o 28a. Date of fnjury (Month, Dey Year) il or Attending Pr eftar death. | Director: After th 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end pieca, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, dete end piaca, end due to the ceuse(s) end menner steted. 29a. Certifier (Check only 29b. Signature end title 29c. License number 29d. Date signed (Month, Dey, Year) D20390 7/10/97 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Dr. Charles Hoesch, 9712 Belair Rd, Baltimore, MD 21236 3. Registrar's Signature 31. Dete filed (Month, Day, Yeer) State JUL 1 5 1997 Registrar



State of Maryland / Department of Health and Mental Hygiene 97

						Cei	tificat	e of	Death		R	eg. No.		to I	0 1 3
			1. Decedant's Name (First, Middla, Las	st)							2. Deta of Dea	th	-	3. Tim	a of Death
	Physici		WILLIAM THOMAS	KELLEY Jr							JULY 1	0 199°	Yaar 7	9:3	O AM
N	/Medi Examir		4e. Fecility Nema (If not institution, give	a street end number	•)				4b. City, To	wn, or Lo	cation of Deeth	4c. County		10.10	
	Exami	161	8150 POTOBAC LA						PORT	TORA	CCO		CHAR	LES	
1	Funeral		5. Social Sacurity Number 6. S		ga (In yrs. lasi	t birthday)	If Undar	1 Year				1	-		ta or Foraign
	Director		213-03-5776	CxM 2□ F	80	Yrs.	Months	Days	Hours	Min.	8. Data of Birth (Month, Day 12/2/1	, Year) .6	100	ntry) LAND	ta or Foraign
	lend w		10a. Stata 10b. County		10c. City, T	own or Lo	cation						1	Od. Insid	a City Limits
	ne Merylen 8a-f ehow ottried et	Director	MARYLAND CHARLE	ES	POF	RT TA									ras 2⊠No
	it ti	- E	10e. Straat and Number				10f. Zip	Code			1	Og. Citizen of	Whet Cour	ntry?	
	23a	0	P.O. Box 272				2	067	7			USA			
	r de	Funeral	11. Maritel Status	12. Was Decedent Armed Forcas	t Ever in U,S.	13. \	Vas Deced	dant of I	lispanic Orl an, Maxicer	gin? (Spen, Puarto	ecity Yes or No- Rican, atc.)		ce - Amaric ck, Whita,		١,
020	s 1 and 2 should be filed within 72 hours efter death with the Merylend Health end Mental Hygiene. tem 27 is marked other than "natural", or items 23s or 28a-f show other traumatic event, the Medical Examinet must be notified at	þ	1 ☐ Navar Married 2 🔀 Married 3 ☐ Widowad 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Yeer or Datas:			I□Yes :					Specif			
21215-0020	n 72 ho "natur	Completed	15. Decedant's Ed (Specify only highest gre	da complated)		6e. Dacad (Giva lifa. L	lant's Usua kind of wo	al Occup rk done	ation during mos d)	t of work	ing	16b. Kind of B			
12	withi ene. than	Ę	Elementery/Secondary (0-12)	College (1-4or	5+)							DEWILL		OWEN	
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an	d d d	Be	WILLIAM T. KELLE										14)		
7	2 should be filed v n end Mental Hygie is marked other t raumatic event, th	T <sub>0</sub>				405 14-115-	_ A JJ	(0)			CE MAY E		01-4-1-70	0.71	
Maryland	d 2 s h en r is r traur		19a. Informant's Name/Ralationship (	**							al Route Number			Coda)	
	ges 1 and 2 t of Health If Item 27 i or other tra		DOROTHY KELLEY  20e. Mathod of Disposition	W		e of Dispo			PORT	TABA	Data ME	2067 20c. Location		oum Stat	
ō	80= 5		1 Sp Burial 2 □ Cramation 3 □	Ramoval from State	com	atary, cran	natory or o	ther ple	ce)	1	Data	200. Location	City or To	JWII, State	
ţ			4 ☐ Donation 5 ☐ Other (Specify		More				l Park		7/14/97	HILLE	NDALE	, MD	
Baltimore,	permit. Pag Department Important: It any injury o		21. Signature of Funeral Service Licen	500		JO	OHNSO	N FU	iss of Facilit JNERAI	HON	1E 8521	LOCH I	RAVEN	BLV	D.
-			23u Fast. Enfer the disease, or comp	nlications that cause	od the deeth. I		OWSON				or respiretony em	act	-	Approxi	meto
-	District		flock or haart failura. List only	one cause on each l	lina.	50 1101 9111	51 1110 11100	ia oi ayii	ng, soon as	our dido t	or raspiratory arr	a 91,		Intarval	Batwean nd Deeth
	Physician /Medical		Immediate Causa /Final	- 0	-1 - 0	0		_ (	20		0-0				
	Examiner		Immediate Ceusa (Final diseasa or condition rasulting In death)  e. CAMCER OF PROSTATE  Due to (or es a consequence of):												
		ā	20-30-00		Due to (or es	s a conseq	uance of):								
	ted nsit	Examiner	•	b			,								
	icete be executed physicien and s the burial-trensit	xar	Sequantially list conditions, if any, leading to immadiate cause. Entar Undarlying Ceuse (Disease or Injury c.										į		
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387	ertificete l ding physise es the l	Medical	that initiated evants  Due to (or as a consequence of):									İ			
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80	eeth cert ettending for use	lan													
o.	the d	Physician/	Pert II. Other significant conditions of	ontributing to death t	but not resultin	ng In the ur	nderlying c	eusa gi	van in Part I	•	23b. Did to	obacco use co	ntribute to		
Δ.	requires that the deeth certificate be executed seen signed by the ettending physicien and hould be detached for use as the bunal-trensit										1 U Y	es 2 No	3 Pro	bably 4	Unknown
Records,	sign d be	1 by									04- 144		T 24h W	ore autor	sv findings
0	v require been si should	etec									24a. Was a perform	med?	av	ailable prompletion	ior to
ec	law as b	Completed											of	daath?	Or Gauga
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1	PI	Be	25. Wes casa rafarrad to medical examinar?						26. Placa	of Deatl	n (Check only or	70)			
Ž	0.6	2	1□ Yas 2□ No	Hospital: 1 ☐ Inpati	ient 2□ER	/Outpatien	t 3□ DC	DA Oth	nar: 4□ Nu	irsing Ho	me 5 Resid	ence 6 □Oth	nar (Specif	(y)	
6	D 90	:uo	27. Manmer of Deeth 1-D Netural 5 ☐ Pending	28a. Dete of Inju (Month, De	ury 28	b. Tima of Injury	2	8c. Inju Wo	ry at rk?		28d. Dascribe h	ow injury occur	red		
9	lendih leath. lor: A the fu	atle	2 Aceidant Investigation	i i			M		Yas 2	No					
Division	N S S S	Certification:	3 Suicida 6 Could not be determined	28e. Plece of in building, e	jury - At home tc. (Specify)	, farm, stre	et, factory	, offica			28f. Location (S City or Tow	treet and Numi n. Stata)	ber or Rura	al Routa /	Vum <i>ber</i> ,
			0												
	To the Hospital or within 24 hours afte To the Funeral Discompletely filled in	edical	29a. Certifiar (Check only one) 10 Certifying Phy 2 Madical Exam	ysician: To the best liner: On the basis of and manner si	of exeminetion	dge, deeth end/or inv	occurred astigation,	at tha ti	ma, data an opinion, daa	d place, th occurr	and dua to the c ed at tha tima, d	euse(s) end m lete and place,	anner es s and due to	teted. o lha ceu:	sa(s)
	To the within 2 To the comple	Me	29b. Signeture end titla of certifier		Α	_	290	. Licans	se number		2	9d. Data signe	ed (Month,	Day, Yes	r)
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	i		20 Name and address of	ompleted as	don't /tr co	1/~	Deimt			, , , ,		/ /		1/	
	, /		30. Name and eddrass of person who c	Annipiated causa of C	Oeatin (item 23	(Type, I	aP(	a.l	ta	3	of 1	-064	16		
	Sta	te	31. Data filed (Month, Day, Year)	32. Ragist	rar's Signatura	1									
	Registr	ar	.111 1 5 1007	Gilia To	· 70 ·										



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR I tem: 7per F. H G-749 7/15/97 RERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH hard Kina 50 4. SOCIAL SECURITY NUMBER 5. SEX AGE (In yrs. lest birthday) 7. DATE OF BIRTH1 1 / 21 / 1 (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. s. BIRTNPLACE (State or Foreign 1 (M 2 | F 9 Alabam 1-07-717 1704 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN Battomore City DIRECTOR Manor NWERDA Home 10e. STATE 10b. COUNTY 10c. CITY. TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Baltimore 1 X YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3314 burial-transit AVR Monelawin after death. Page 6 may be retained by the hospital or attending physician, by the funeral director, page 5 should be detached for use as the burial-tran 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married 1 TES 2 NO Specify: BY Black 3 Widowed 4 Divorced 0 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16b. KIND OF BUSINESS/INDUSTRY COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) 12 Grado Able Body Seaman Merchant Seaman once. 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) notified at Richard King BE Alice Bodan 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Marvetta King/wife 3314 Mondawmin Ave. Baltimore, MD 21216 pe 20s. METHOD OF DISPOSITION
1 □ Burlel 2 to Cremetion 3 □ Removal from State
4 □ Donetion 5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must Metro Crematory. Inc. 7/14/97 Baltimore, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE medical examiner 22. NAME AND ADDRESS OF FACILITY McDonald My Cremation Society of Md., Inc. in by the fi 299 Frederick Rd. Baltimore, MD 21228 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Illed in ! shock, or heart fallure. List only one cause on each line. Interval Between 6 Onset and Daath IMMEDIATE CAUSE (Final Br Curoma the cremation, disease or condition Marlin resulting in death) traumatic event, complete DUE TO (OR AS A CONSEQUENCE OF): executed prior to burial, CERTIFICATION and Sequantially list conditions, if any, laading to immediata DUE TO (OR AS A CONSEQUENCE OF): attending physician the death certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST the atten Injury, DIVISION OF VITAL RECORDS, PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS by PERFORMED? AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE OF DEATH? Health a 1 YES 2 DING 1 YES 2 NO рееп has been Dept. of F PHYSICIAN: OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate h EXAMINER? HOSPITAL: 4 UNUTSIN 1 | Inpatient 2 | ER/Outpatient 3 | DOA ing Home 5 - Residence 6 - Other (Specify) or the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED with marked, this ( 1 Nettral 5 Pending L DIRECTOR, After the bours after death w 1 YES 2 NO BY Investigation 2 Accident 3 Sulcide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide TO THE FUNERAL DIRECT
OF MED WITHIN 72 HOURS AT
IMPORTANT: If item 2 29e. CERTIFIER

(Chack only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time. 296. SIGNATURE AND TITLE OF CERTIFIER 29d, DATE SIGNED (Month Day Year) 黑黑黑 Allenday Doclar Cympe M7 PPS 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CYRIAC- M.D 8109 6007 32. RECUSTRAN'S SIGNATURE 31. DATE FILED (Month, Day, Year)

PB

5 1997

July Driggen- Randell

DHMH-16 Rev 1/89

		State of Mary		epartment of F Certificate of	lealth and Mental Hy Death	ygiene 97	21381
Physici /Medic	cal	Decedant's Nama (First, Middle, Last)     AR RA     A Recility Nema (If not institution, give streat and number)		LEZIV	2. Data of D Month JULY 4b. City, Town, or Location of Dea	13 199	3. Time of Death
Examir Funeral Director	ner	LORIEN NURSING 1-	OM (	(ay) If Under 1 Year Months Days	COLUIMB   A If Under 24 Hrs. 8. Data of B. Hours Min. JAN.	HOWA	1
deeth with the Merylend ms 23a or 28a-f show r.mst be notified at	ector	md HOWARD	c. City, Town o	r Location			10d. insida City Llmits 1 🕱 Yas 2 🗆 No
th with the 23a or 2	Funeral Director	10e. Straat and Number 7080 CRADLEROCK WAY APT. 20	6	10f. Zip Coda 210	)45	10g. Citizen of What RUSS	
s 1 and 2 should be filed within 72 hours efter deeth with the Meryle if Heelth end Mental Hyglene. If Heelth end Mental Hyglene. Iftern 27 is marked other than "natural", or items 23a or 28e4 show other traumetic event, the Mudical Examiner must be notified at	b	11. Marital Status  1 Never Merried 2 Married  3 Widowad 4 Divorced  12. Was Decedant Eve Armad Forcas?  1 Yes 25 No If Yas, Give Yaar or Detes:	r in U,S.	13. Was Decedant of H If Yas, specify Cub 1 ☐ Yas 2 ☐ No	dispenic Origin? (Specify Yas or N an, Maxican, Puerto Rican, atc.) Specify:		wherican Indian, Whita, atc.
in 72 hc n "natur Ned col	Completed	15. Decedant's Education (Spacify only highast grada complated)	(6	ecedent's Usual Occup iva kind of work dona ia. DO NOT usa retire	during most of working	16b. Kind of Busine	ess/Industry
filed within Hyglene. other than "	Be Com	Elementery/Secondary (0-12) College (1-4or 5+)  NONE  17. Fathar's Nama (First, Middla, Last)		HOMEMAKER	18. Mothar's Nama (First, Middle	OWN H	IOME
ould be Mental mrked o	To B	MOTL	TSINKE	ER	YENTA	UN	IKNOWN
end 2 sho selth end r 27 Is m		19a. Informant's Name/Relationship (Type, Print)  MUNYA LEZNIK (SCN)		lailing Addrass (Straat 180 CRADLEF	end Number or Rural Routa Num ROCK WAY #320	ber, City or Town, Star COLUMBIA	
permit. Pages 1 end 3 Department of Heelth Important: If Item 27 I any Injury or other tr. once.			20b. Place of Di	sposition (Nama of cremetory or othar pla	Data	20c. Location - City	
permit. Pages Department of Important: If it any injury or once.		21. Signature of Egnaral Sarvice Licensaa	AKBIM	22. Nama and Addra		INC.	
Physician /Medical Examiner	)r	23a. Part1. Entar the disease, or complications that caused the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	ſ.	3) leg		arrast,	Approximata Interval Batween Onsat and Death
eath certificete be executed ettending physician end for use es the buriel-transit	n/Medicai Examiner	if any, leading to immadiate causa. Entar Undarlying Causa (Disass or Injury	to (or as a con	saquence of):	sease	D	
requires that the death certifical seen signed by the ettending phy hould be deteched for use es th	y Physician/Med	Part II. Other significant conditions contributing to death but not Institute a Leptender death death					uta to the causa of dear
_ 0 0	Completed by					s an autopsy formad?	bb. Wara autopsy finding available prior to complation of causa of deeth?
The ate h page					10	Yas 2 No	1 □ Yas 2 No
Physician: The this certificate rel director, pag	o Be	25. Was case rafarred to medical axaminer?  1  Yas 2 No Hospital: 1 Inpatiant	2□ EB/Outos	etient 3 DOA Oth	26. Placa of Daath (Check only er: 4 Nursing Homa 5 ☐ Ras		De acife i
ing Ph After th funerel	ation: T	27. Manner of Death  1 Matural 5 Pending invastigation 2 Accident (Month, Day Ya	28b. Tim	a of 28c. Injur		how injury occurred	респу)
after death after death In Diractor:	Certification:	4 ☐ Homicide building, atc. (S	ipecify)	street, factory, office	City or To	(Straat end Number o own, Stete)	
Please Fund	edical	29a. Certifier (Check only one)  1	mination and/o	eeth occurred et tha tir r Invastigation, in my o	na, dete end place, end dua to the pinion, daath occurred at tha tima	e causa(s) and manna , data and place, and	r as stated. due to the ceusa(s)
1 2 8	¥	29b. Signature and title of certifier		29c. Licens	6 1338 6 MD, 21044	29d. Data signad (M	

State

M	Ι	C	Η	A	Ē	L
Τ.	E	В	R	IJ	N	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

)	97	2 1	2	0	6
	7 1	21	J	0	-

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Michael E. LeBrun

10b. County

Howard

15. Decedent's Education (Specify only highest grade completed)

1 ☐ M 2 ☐ F

If Yes, Give Year or Dates:

NEWBURG AVE

5. Social Security Number

1 Never Married 2 ☐ Married

3 Widowed 4 Divorced

**Funeral** Director

Director Funerai þ

217-98-7454 Usual Residence of Decedent 10e. Stete 10e. Street end Number

Md

Completed

Physician /Medical Examiner

physicien end the buriel-trensit The lew requires that the death certificate be executed 80 esn certificate hes been signed by the rector, pege 2 should be detached Attending Physician: this funeral er death.

P.O. Box 68760,

Division of Vital Records,

Peges 1 end 2 should be filled within 72 hours after death with the Merylend nent of Health end Mentel Hygiene.

int: If Item 27 is merked other than "natural", or items 23a or 28a-f ahow ury or other traumatic event, the Medical Evanmer must be notified at Be ပ permit. Pege Department of Important: If any Injury or once.

altimore, Maryland 21215-0020

Elementery/Secondery (0-12) College (1-4or 5+) Helper 17. Fether's Neme (First, Middle, Last) Unknown 19a. Informent's Name/Relationship (Type, Print) Emily Ruth Adams/Mother 20b. Place of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition N Burial 2 □ Cremation 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) Lorraine Park 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility mp ! 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final Hanging diseese or condition resulting in death) Due to (or es a consequence of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initleted events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or as e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert t. þ Completed 25. Wes cese referred to medical Be 26. Plece of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: ပ 1 ☐XYes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Certification: Found 4:004M 1 Naturel 5 Pending 1 ☐ Yes 28 No investigation 2 Accident 7-13-97 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Home 29a. Certifier (Check only one) Medicai 29b. Signature end title of cartifier 29c. License number

2. Date of Deeth 3. Time of Death Month 1997 JULY 13 2:05P.M. 4e. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth CATONSVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplaca (State or Foreign Country) Months Deys Hours Yrs 30 Feb 4, Md 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Columbia 10f. Zip Code 10g. Citizen of Whet Country? 21044 10850 Green Mountain Circle #217 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indlen, Bleck, White, etc. 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Specify: Specify: white 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Liquor Distributor 18. Mother's Name (First, Middle, Meiden Sumeme) Emily Ruth Adams 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 10850 Green Mountain Circle #217 Columbia, Md21044 20c. Location - City or Town, Stete 7/17 Baltimore, Md. Sterling Ashton Funeral Home, Inc 736 Edmondson Avenue, Balto, Md. 21228 Approximete Intervel Between Onset end Death

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 □ Unknown

24a. Wes en eutopsy performed?

24b. Were eutopsy findings eveileble prior to completion of cause of deeth?

1 X Yes 2 □ No

1 Yes 2 No

28d. Describe how injury occurred

Subject hanged himself
281. Location (Street end Number or Rurel Route Number,
City or Town, State) 12 Newburg Svenue
Ralbinous Constitution Baltimore County, Maryland

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner stated.

O.C.M.E.

29d. Date signed (Month, Day, Yeer)

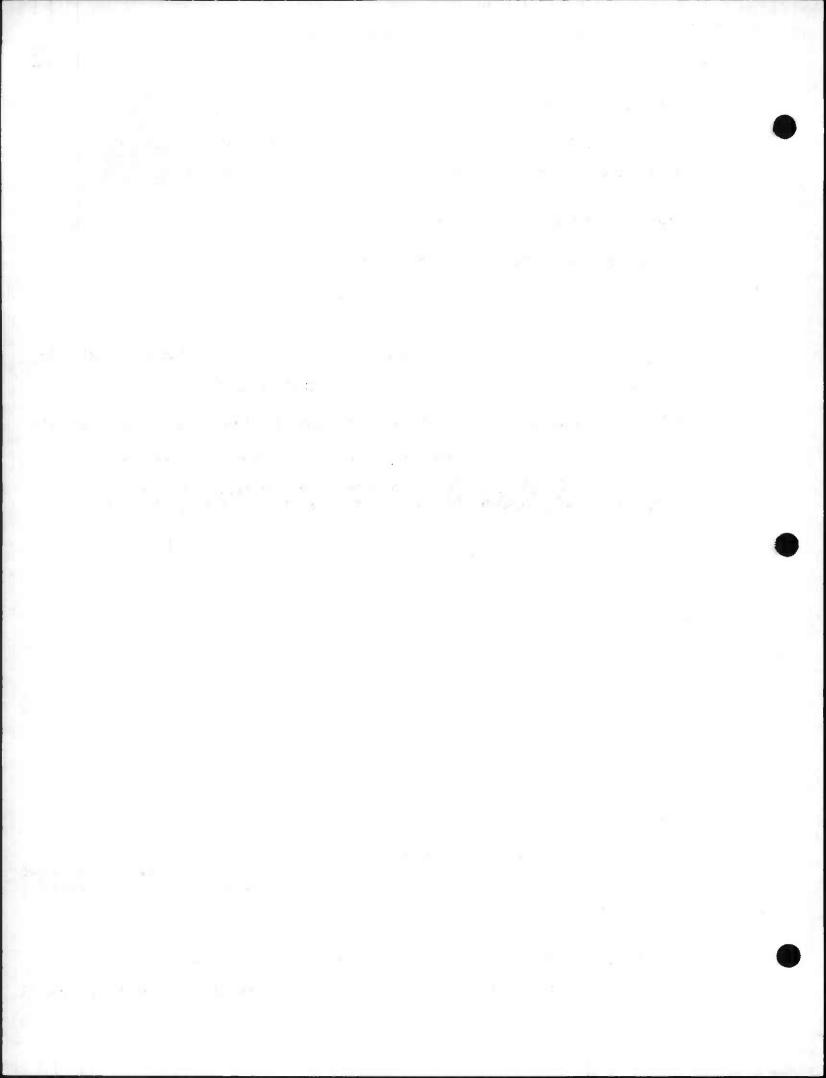
JULY 14, 1997

MP 30. Name end address of person who completed cause of deeth (flem 23a) (Type, Print)

Stephen S, 31. Date filed (Month, Day, Yeer) JUL 1 5 1997

S. Padentz, Mp 111 Penn Street, Baltimore, Maryland 21201 which endoon-handell

State Registrar



State of Maryland / Department of Health and Mental Hygiene 97

21383

				,		Cert	ificate of	Death		Reg. No.	1 6	21000
	Physici	an	1. Decedent's Neme (First, Middle, I	ast)	CV		11	111	2. Dete of D Month		Yeer	3. Time of Deeth
	/Media		UUSEPH	PAIKIC	1		LAI	VE	JULY	12,19	797	4: AM
	Examir	ner	4a. Fecility Neme (If not institution, g	ive street and number)				4b. City, Town, or			of Deeth	
			MAKBUK A	037711AL	CEI		-	BALITI	/ / ~	N/A		
	Funeral Director		5. Social Security Number 6. 213-09-2582	12XM 2□ F	yrs. last bin		Months Deys	Hours Min	. (Month, D	ey, Year)	Count	ace (State or Foreign try) LAND
н			Usual Residence of Decedent		J.J.				AUG Z	4 1913	1114(1	ZHIII
	how		10a. Stete 10b. County	100	c. City, Town	n or Loca	tion				10	Od. Inside City Limits
	e Me	cto	MD BALTIM	IORE	DUNI	DALK						1 ☐ Yes 2 🖸 No
	or 26	Oire.	10e. Street end Number				10f. Zip Code			10g. Citizen of	Whet Count	ry?
	23a	ie.	2442 KEYWAY				21	.222		US	SA	
	r deg	Funeral Director	11. Marital Status	12. Wes Decedent Ever Armed Forces?	in U,S.	13. Wa	s Decedent of H	dispenic Origin? (S an, Mexican, Puer	Specify Yes or Notice Rican, etc.)	0- 14. Rac	ce - America	
21215-0020	filed within 72 hours efter death with the Meryland Hygiene. ther than "natural", or items 23a or 28s-f show thit, the Medical Examiner must be collined at	by	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced				]Yes 2⊠No		,	Specify		
5-0	72 h	Completed	15. Decedent's (Specify only highest of	Education	16e.	Deceder (Give kir	nt's Usual Occup	etion	rkina	16b. Kind of B	usiness/Indi	ustry
21	within ene. then	npje	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)				during most of wo	rking			
	Hygier Hygier ther th			2		SHI	PBUILDE			Beth.		
and	to do oth	Be	17. Fether's Name (First, Middle, Las	•				18. Mother's Na	me (First, Middle	, Maiden Sumen	10)	
Ĕ	should be filed end Mentel Hygi s marked other sumatic event,	To	BARTHOLOMEW A					WANEI		CUNNING		
Maryland	d 2 sh h end ls n traun		19a. Informant's Name/Relationship		19b.	. Meiting	Address (Street	and Number or R	u <i>ral Rou</i> te Numi	per, City or Town,	Stete, Zip (	Code)
	s 1 end 2 should be filed withi f Health end Mentel Hygiene. tem 27 is marked other than other traumatic event, the M		BARBARA SARLIN, 20a. Method of Disposition				OLF COUR	SE DRIVE	, ARNOL			- 01-1-
õ	00 ==		1 ☐ Burial 2 ☐ Cremation 3	Removel from State	cem eter	y, creme	tory or other pla	ce)	Date	20c. Location -	City of Tow	WI, State
Baltimore,	permit. Pag Depertment Important: Ii any Injury o		4 ☐ Donation 5 ☐ Other (Special Signature of Funerel Service Lice		CHESAF		CREMAT		7-13	BELTSVI	LLE,	MD
Ba	permit. Depertrimports any Inju	1	A Parles &	Haeli		BRA		HTON FUN			2122	2
			23a. Part1. Enter the disease, or co shock, or heart failure. List only	mplications thet caused the	death. Don	not enter	the mode of dyir	W SPRING	c or respiretory	ALT., MU		Approximate
	Physician		snock, or neart failure. List on	y one cause on eech line.								Intervel Between Onset end Deeth
70	/Medical		Immediate Ceuse (Finat disease or condition	· ADENIOC	ARCI	NO	MA I	RIGHT	-	21011		weeks
	Examiner		resulting in death)									1 yr +
	Si 9d	ine		Due b NON 1N90	LIN	DET	PENDEN	VT DIA	BETES	MELL	, ,	
	Physician: The law requires that the deeth certificete be executed this certificete has been signed by the ettending physician end are director, pege 2 should be deteched for use as the buriel-trensit	Examiner	Sequentially list conditions,	Due	to (or es e d	onseque	nce or):					
68760,	be ey ician burie		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	. CORONA	IRY	AR	TERY	DIBEI	15E		1	41 +
387	phys the	Medicai	thet Initieted events resulting in death) Last	Due t	to (or es e c	onseque	nce of):					
Box (	certifica ding pl			d. PERITON	1773	, 4	NASTO	MOTIC	LEAK		19	days
ğ	that the deeth cer ed by the ettendir deteched for use	by Physician/	Part II. Other planificant conditions	anatality is land a stand by a set		Ale a const	4.4	COLD BOWL	005 014	A.b	11	No. of the alliance
P.0.	t the de by the teched	hys	Part II. Other eignificant conditione							Yes 2 No	3 ☐ Prob	the cause of death?  ably 4 Unknown
	res that igned to be det	y P	MALNUTRIETI	ON, HYF	OPR	OTE	INEM	14	''	108 2000	3 Prob	abiy 4 Olikilowii
of Vital Records,	v require been sig should b									en eutopsy	24b. Wei	re eutopsy findings
000	s bec	Completed							pen	ormed?	com	ileble prior to apletion of cause leeth?
æ	The law te has sege 2	E							10	Yes 200No	10	Yes 22 No
ita	ysician: The l s certificate ha director, pege	Be C	25. Was case referred to medical					26. Plece of De	ath (Check only			
>	nysic nis ce	To	examiner? 1 ☐ Yes 2 No	Hospital:	2□ER/Ou	tpetient	3□ DOA Oth	ner: 4 ☐ Nursing I	Home 5 ☐ Res	idence 6 □Oth	er (Specify	)
	tending Phi leath. tor: After thi the funeral		27. Menner of Death  1 Netural 5 ☐ Pending	28a. Dete of Injury (Month, Day Yea	28b. T	ime of	28c. Injur Wor	y et rk?	28d. Describe	how injury occur	red	
Sio	Attending or death. sctor: After by the fune	cati	2 Accident Investigati 3 Suicide 6 Could not				M 1 🗆	Yes 2 □ No				
Division	Hospital or Attending I 24 hours efter death. Funeral Director: After tely filled in by the funer	Certification:	4 Homicide determine	28e. Plece of Injury - A building, etc. (Sp	At home, fer pecify)	rm, street	t, factory, office			(Street end Numb wn, Stete)	er or Rural	Route Number,
	Hospital 24 hours e Funeral C		29a. Certifier 12 Certifying F	husialan Taska kastafaa	1 1 1-		1.1.1.					
	Hos 24 hr Fun etely	edicai		hysician: To the best of my miner: On the basis of exan and manner stated.	nination end	dor inves	stigation, in my o	ne, dete end piece pinion, death occi	arred et the time,	date end place,	end due to	the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier				29c. Licens			29d. Date signe	d (Month, D	ey, Year)
1	A		1 / Loulla	no all			D2	8988		VULV	12.1	997
,	1 /0		30. Neme end eddress of person who		(Item 23e) (	Type, Pri	int)			VULY	2	1225
-	10		LINO R. ARG	CILLANO	YD.	300	1 500	TH HAN	OVER	51 E	3417.	MD
	Sta	te	31. Dete filed (Month, Day Year) JUL 1 5 1997	32 Registrare S	ignature 2	2			-			
	Registr	ar	UOL 1 9 1331	0	-							

Registrar

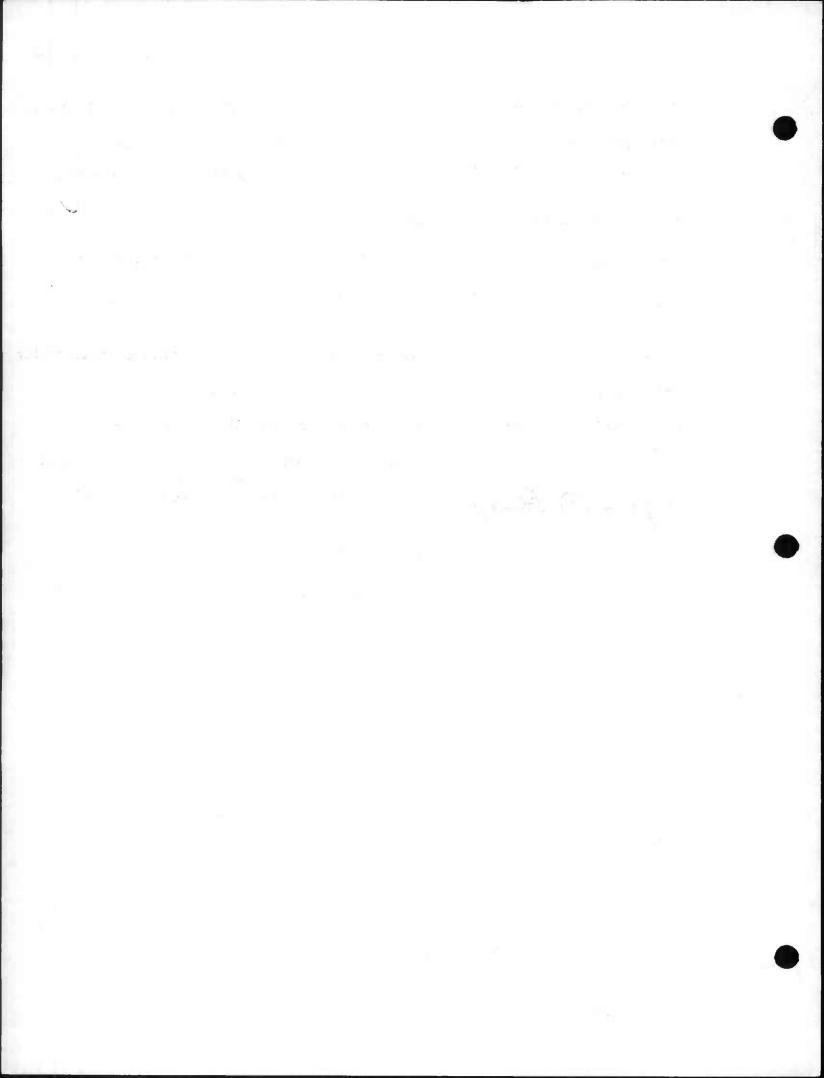
P. b. 

State of Maryland / Department of Health and Mental Hygiene 0.7

						ate of L			Reg. No.	1 1	21384
	Physic /Medi		1. Decedent's Nema (First, Middle, Last) SHELDON	6	ENE	NBE	RG	2. Dete of De Month	Day	Year 197	3. Time of Death 500pm
	Exami		11/11/01	OSPI		0	ACTIMON	E CITY			
	Funeral Director		5. Social Security Number  215-30-5280  Usual Residence of Decedent  6. Sex  1 M 2 F 63	. last birthda Yrs.	Month	dar 1 Yaar is Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March	in, Year) 10, 1934	9. Birthp Cour UT	pleca (Stete or Foreign ntry) nknown
	e Maryland	ctor	10a. State 10b. County 10c. Ci	ity, Town or altimo							10d. Inside City Limits 1 Yes 2 No
	ter death with the Marylan Rems 23a or 28a-f show Incr munt be notified at	Funeral Director	10e. Street end Number 501 West Franklin Street		21	Zip Code L201			U.S.A.		
020	n 72 hours after death with the Maryland *natural', or items 23s or 28s-f show edical Examiner must be notitied at	by	11. Maritel Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in L Armed Forces? unkr  1 Yes 2 No If Yes, Give Year or Dates:	iown 13		cedent of His pecify Cubar 212 No	spanic Origin? (S n, Mexican, Puart Specify:	pecify Yes or No o Rican, etc.)		e - Americ k, White, Whi	
21215-0020	I within 72 he iene. Than "nature" the Medical	Completed	15. Decedent's Education (Spacify only highest grada completed)  Elementary/Secondary (0-12)  unknown  College (1-4or 5+)  unknown	16e. Dec (Gin life	va kind of No. DO NOT		tion u <i>ring</i> most of wor	king	16b. Kind of Bu		dustry
	e filed of Hygic other	Be C	17. Fathar's Nama (First, Middle, Last)	.1	GIIKII		18. Mothar's Nar	na (First, Middle,	Maidan Surnam	e)	
lar	should be and Mentel marked o	To B	unknown				unknow	n			
Maryland	2 sho end I ts me	ľ	19a. Informant's Name/Relationship (Type, Print)	19b. Me	eiling Addre	ess (Street e	nd Number or Ru	rei Route Numb	er, City or Town,	State, Zip	Code)
Baltimore, N	Parmit. Pages 1 and 2 should be filed within 7 decarment of Health end Mentel Hygiene. Important. If them 27 is marked other than "n my fillury or other traumatic event, tra Medianse.		4 □ Donation 5 ₺ Other (Specify Ln State	centetery, cr	48 Ch sposition (A rem <i>atory</i> of	urch   lame of r other plece	Lane Bly	d B1, Cl	nesapeak 20c. Location -	e V: City or To	irginia2332 own, State
Balt	permit. Pa Departmen Important any injury 2059.		21. Signature of Funeral Service Licensee Ronald S. Wade Direc	1	State Balt	end Address e Anat imore	of Facility Comy Boa Maryla	rd, 655 nd 21201	W. Balt	imor	e Street
Box 68760,	Physician /Medical attending water and attending water and attended to the property of the pro	n/Medical Examiner	if eny, laading to immediate cause. Enter Underlying Ceuse Disease or injury	ORY or es e cons OIA. or es e cons	FAI sequence o sequence o RUC	LURU 11): 11): TIVE	E		DISTH:	E	Onset end Death
Ö.	death	Physician/N	Pert II. Other eignificent conditione contributing to death but not res	sulting In the	underlying	cause give	n in Part I.	23b. Dld	tobacco uea cor	itribute t	o the cause of death?
s, P.O.	requires that the death certi ween signed by the attending hould be deteched far use e	by Phy						1 🗆	Yes 2□ No	3□ Pro	bably 4 Donknown
Vital Records,	S S ×	Completed							an autopsy ormed?	av	ere eutopsy findings ailable prior to impletion of cause death?
a	T ate		05 Western 19					10'	- 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1	1[	☐Yes 2☐ No
₹		To Be	25. Wes case referred to medical examiner?  1  Yes 2 No Hospitel: 1 The matternt 2	ER/Outpeti	ient 3□ t	Othe	p.	th (Check only o	one) dence 6 □Othe	(Ci	F-1
sion of	ing Ph a. After th funerel		27. Menner of Death  1. Naturel 5 Pending (Month, Day Year)  2 Accident investigation	28b. Time Injury	of	28c. Injury Work			how injury occurr	1-1-1-	у)
Division	To the Hospital or Attending Phy within 24 hours effer deeth. To the Funeral Diractor: After thi completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Specification)	fy)		•		City or Tox			
	Hosp 24 ho Fund etely f	edicai	29a. Certifier (Check only one)  2   Medical Examiner: On the best of my knot one)  Medical Examiner: On the best of examinar end manner steted.	wledge, dea ation end/or	ath occurre investigation	ed et the time on, in my op	a, date end plece inion, death occu	, end due to the rred et the time,	cause(s) end me date end place, a	nner es s	teted. the ceuse(s)
	To the Within To the	Me	29b. Signature and title of certifiar		2	9c. Licanse	number		29d. Data signed	(Month,	Day, Year)
			tary tomin M.D.			80	1295	- 1/1/97 PAL Hospital			
			30-Name end address of person who completed cause of deeth (Iter Parag Lat Sania, m.D. G	n 23e) (Type	e, Print)	bid c	GENERA	L Hos	oital		
	Sta Registr		31. Dete filed (Month, Dev. Year)  JUL 1 5 1997  JUL 1 5 1997	HREBE.							

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 2 1 3 8 5

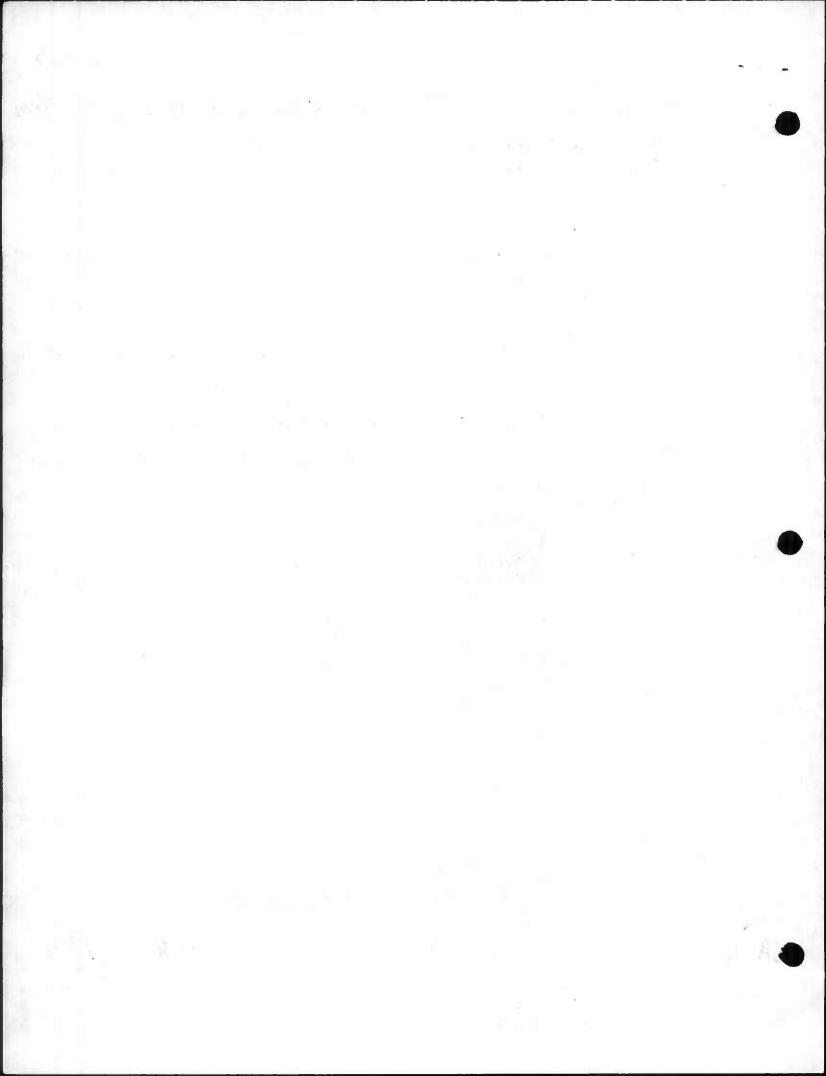
						C	ertificate of	Death		Reg. No.			
	11,		1. Decedant's Name (First, Middla, Li	ast)					2. Data of De	eath	N/III	3. Tima	of Death
7	Physici /Medi		Grace Concetta L	eisher					Month July	Day 13	Yaar 1997	1:00	a.m.
	Examir		4a. Facility Nama (If not institution, gi	e street and number)				4b. City, Town, or L					
			7936 Bank Street					Baltimore		Bal	timore	2	
	Funeral				a (in yrs. i	ast birthda	Months Days		8. Data of Bir (Month, Da	th V Year)	9. Birthp	ace (State	a or Foreign
	Director		214-14-9626	1□ M 2180 F 7	5	Yrs.	Wortens Days	TIOUIS IVIIII.	March	12, 192	2 Ma	rylan	
	pu ,		Usual Residence of Decedant		10- 04	-					1.		
	show	-	10a. Stata 10b. County			, Town or					1		City Limits
	Ba-f	Director	Maryland Baltimo	re	ватт	imor							15 2023190
	ith t	F	10e. Street and Number				10f. Zip Coda			10g. Citizan of	What Coun	try?	
	ath v	ra.	7936 Bank Street				21224			United			
	er de	Funeral	11. Marital Status	12. Was Dacedant   Armed Forcas?		5. 1	<ol><li>Was Decedant of if Yas, specify Cul</li></ol>	Hispanic Origin? (Sp ban, Maxicen, Puarto	pecify Yas or No Rican, etc.)	- 14. Rac Bla	ce - Amaric ck, Whita,		
20	s eff	by F	1 ☐ Navar Married 2 ☐ Married 3 ☑ Widowad 4 ☐ Divorced	1 ☐ Yas 2 🕅 If Yas, Give	No		1 ☐ Yas 2 🔀 No	Spacify:		Specif	y: Whi	te	
Maryland 21215-0020	be filed within 72 hours efter death with the Meryland tal Hygiene. d other than "netural", or Items 23e or 28a-f show event, the Modical Examiner must be notified at			Yaar or Datas:		10- D-	and and a Harris Cons		_	405 Kind of B			
15	"ne"	Completed	15. Dacedant's E (Specify only highast gr			(Gi	cedant's Usual Occu va kind of work done o DO NOT use retin	a during most of work ed)	king	16b. Kind of B	usiness/inc	lustry	
12	within ene. then "r	m	Elementary/Secondery (0-12)	College (1-4or 5	i+)	_	nstress	50)		Clothir	o Mar	ufac	turina
D	al Hygie other		17. Father's Name (First, Middla, Las	")		bear	iis cress	18. Mothar's Nam	a (First, Middle			urac	curing
an	should be and Mental simarked or umatic eve	o Be	Frank Garbo					Anglina			al.		
7	2 should be end Menta is marked aumatic ev	٩	19a. Informant's Name/Ralationship	(Typa, Print)		19b. Ma	ailing Address (Stree	at and Numbar or Ru			Stata Zin	Coda)	
S	d ta		William Leisher	/ Son				de Avenue			21131		
ē,	s 1 and 2 should f Heelth end Mer fern 27 is marke other traumatic		20a. Mathod of Disposition	, 2011	20b. Pl	ace of Dis	position (Nama of		Data	20c. Location			
2	ages intof intof		1XD'Burial 2 ☐ Cramation 3 [		1		ramatory or other pl		7/16/07	Baltimo			and
Baltimore,	it. Portme		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		New	Gati	nedral Cet 22. Nama and Addi						and
Ba	permit. Pages 1 an Depertment of Heel Important: If Item 2 any injury or other once.		21. Signature of Furnarian Sarvice Ecce	01 11.				ens Avenue		ark Fune			
			Jame )	Phillips	0						ID 21	229	
			231 Part Entar tha disaase, o con shock, or haart failure. List only	ona causa on aech lir	tha death na.	. Do not	enter the mode of dy	ring, such es cardiac	or raspiratory a	rrast,	i i	Approxim tntarval B Onsat and	atween
	Physician / /Medical		Immadiata Causa (Final				. 1	0 . 0			1		
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Division of Vital Records,	The law requires that the ate hes been signed by the pege 2 should be detache	d b							24a. Was	an autopsy	24b. We	re eutops	y findings
000	w require been si should	Completed							parfo	ormed?	COL	nilabla prio nplation of deeth?	
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5	Physicien: The I this certificate he rel director, pege	8	examinar?	Hospital:	-1 001	200		26. Place of Dea					
ō	Phys r this arel di	: To	27. Manner of Death	1 ☐ Inpatie		R/Outpat 28b. Tima	Marit SE DOA	4 🗆 Huising Fi		dence 6 Otl		′)	
o	ding h. Afte	tior	1 Panding 2 Accident 5 Panding investigation	28a. Date of Injur (Month, Day	Yaar)	Injur	y W	ork? □Yes 2□No		,,,,,			
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S	efter Dire	Certification:	4  Homicida	building, ato	. (Spacify)		straat, factory, office		City or To	wn, Steta)			
	spita ours neral		29a. Certifiar 1 Certifying Pl	yaicien: To tha best o	of my know	ledge, de	ath occurred at the t	time, date and place.	and dua to the	causa(s) and m	annar es st	eted.	
	In the Hospital or Attending Phys whin 2 hours after death. It the Funeral Director: After this completely filled in by the funeral directions.	edical	(Check only one) 2 Medical Example (Check only one)	niner: On the basis of and mennar sta	axaminati	on end/or	invastigation, in my	opinion, daath occur	red at tha tima,	data and placa,	and dua to	tha causa	i(s)
52	1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Me	29b. Signatura end titla of certifi	1			29c. Licer	nse number		29d. Date signe	ed (Month,	Dey, Year)	1
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State of Maryland / Department of Health and Mental Hygiene 97

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Tr. Fathar's Name (First, Middla, Last)  WILLIAM COOK  19a. Informant's Name/Ralationship (Typa, Print)  CORNELLI, S. MORT				18. Mothar's Na		Maiden Sumama)	
	ron-son	19b. Mailing Addre				or, City or Town, Sta	
20a. Mathod of Disposition  20a. Mathod of Disposition  XIXI Muricial 2 Cramation 3 Ramoval for A Disposition	rom Stata cen	ca of Disposition (A matary, crematory o	r othar place		Data 7-17-97	20c. Location - City	y or Town, State  MORE CO., MD
4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	1 shows	22. Nama	and Addrass	1			
Physician //Medical Examiner  23a. Pert1. Entar the disaasa, or complications the shock, or heart failure. List only one causa  Immediate Ceusa (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants rasulting in death) Last  d	Dua to (or a	Me Jk es a consequance of as a consequance of	as Ja 10: P):	Sis			H AVENUE Approximate Interval Batwaan Onsat and Doath  5 marchs 13 months
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ew requires to the second of t					24a. Was a	an autopsy 2 med?	4b. Wara autopsy findings eveilable prior to complation of causa of death?
The state of the s				26. Placa of Das	1 ☐ Y	21 11	1 Tas 2 No
25. Was casa raferred to medicel axaminar?    1	Inpatient 2 EF ata of Injury Month, Day Year)	R/Outpetient 3 to 1 8b. Time of Injury	28c. Injury	4 LI Nursing H		ance OCOthar (a ow injury occurred	specify) HOSPICE
Ser O	laca of Injury - At home uilding, etc. (Spacify)				City or Tow	n, Stata)	or Rural Route Number,
7 5 7 0	the best of my knowle a basis of axamination nanner statad.	edga, daath occurre n and/or invastigatio	d at tha tima on, In my opi	, date end place nion, daath occu	, and dua to the o rred at tha time, o	ausa(s) end manna lata and place, end	ar as stated. dua to tha ceuse(s)
29b. Signatura and title of certifier			9c. Licansa			9d. Data signed (N	14,199 7
30. Nama and address of person who completed of FERNANDO J.  State 31. Dete filed (Month, Day, Year)	-	40	58	40480 10 B	MD i	21206	'/

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day 1947 4c. County of Peeth nie ture 6:15 PM ul 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death ulti-N lowson Baltimore 7700 ledi (Cu enter  $\mathcal{K}_{\mathcal{A}}$ Hours Min. 8. Date of Birth Min. 10/1.4/1898 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign Country)
S. Carolina 6. Sex 7. Age (In vrs. last birthday) Deys 12XM 2□ F 98 218-10-8205 S. Usuel Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No N/A BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4305 ADELL TERRACE #204 21229 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Yeer or Dates: Wes Decadent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Hospital Emergency Room Assistant 12th 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Walter Bishop Ammie McIntyre 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21228 19a. Informent's Neme/Reletionship (Type, Print) Almie McIntyre, Jr. 34 Kimball Ridge Court, Catonsville, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 13 Burial 2 ☐ Cremetion 3 ☐ Removel from State Loudon Park Cemetery 7/15 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signeture of Funerel Service License 22. Name end Address of Fecility LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO. 21207 omplications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, nly one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Ceuse (Finel or Asystole diseese or condition resulting in deeth) (or es e consequença of) SHD years Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting In death) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? eripher al VAScular 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1□Yes 2XNo 21000

**Physician** /Medical Examiner

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certificate

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Fun within 24 h To the Fun complately 节

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P.O. Box 68760.

Records,

of Vital

Division

**Physician** 

/Medical

Examiner

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Funeral

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Completed

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MD

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examinar must be notified at

pemit. Pegas 1 and 2 should be filed within 72 hours after I Depertment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or thei any Injury or other traumatic event, the Medical Examina

Baltimore, Maryland 21215-0020

with the Meryland

deeth v

Physician/Medical þ Completed

Be

P

Certification:

Medical

25. Was case referred to medical 26. Place of Death (Check only one) exeminer? 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 28d. Describe how Injury occurred

1 Yes 250No 27. Manner of Deeth 1 Natural 2 Accident

3 Suicide

4 Homicide

5 Pending investigation 6 Could not be determined 28e. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury et Work? 1 Yes 2 No

29a. Certifier

12 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medican Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner stated.

29b. Signeture and title of could

Medical Attending

29c. License number

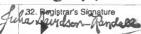
29d. Date signed (Month, Dey, Year)

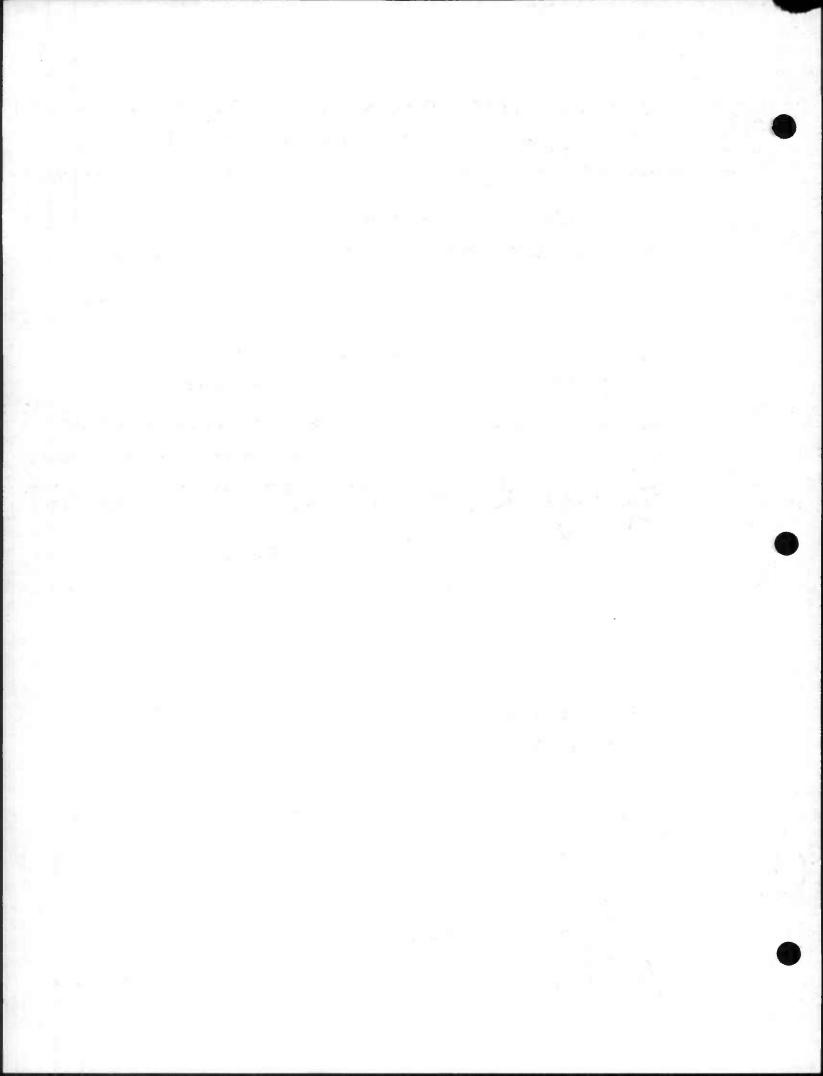
Location (Street end Number or Rural Route Number, City or Town, Stete)

nd address of person who completed cause of death (Item 23e) (Type, Print)

M.D. 4000 Old Court Rd #203 21208 chwartz

State Registrar





State of Maryland / Department of Health and Mental Hygiene 97 21388

						Cei	rtificate	of	Death			Reg. No.		21000
ľ	Dhyois	ion	1. Decedent's Neme (First, Middle, L	est)							2. Dete of De Month	eth Dey	Yeer	3. Time of Death
	Physic /Med		HELEN	ΙE			M	OSE	S		JULY 9	1997	1 001	3:20am
	Exami		4a. Fecility Neme (If not institution, ga	· ·					4b. City, Tov	wn, or L	ocation of Deat	4c. Count	y of Deeth	
			1 SLADE AVE, AF	т. 406					BALTI				TIMO	RE
	Funeral Director		219-40-4165	4 D M 6 D C	e (In yrs. lest 93	birthdey) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, De SEPT.	th y, Yeer) <b>7, 1</b> 903	9. Birthi Coul MA	plece (Stete or Foreig ntry) RYLAND
	pus *		Usuel Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	nation							404 1-11-02-11-2
	anyla eho	5		T14000	roo. Oxy, ro	, O. E.						10d. Inside City Limit		
	28a-	ect	MARYLAND BALT  10e. Streef end Number	IMORE					10RE			40 - 000 - 4	1150	
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Haalth and Mantal Hygians. If item 27 is marked other than "natural; or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	Funeral Director	1 SLADE AVE., A				10f. Zip (		21208			10g. Citizen of USA		ntry?
	ar de	une	11. Maritel Status	12. Was Decedent E Armed Forces?		13.	Was Decede f Yes, specif	nt of h	fispenic Orig en, Mexican	gin? (Sp , Puerto	ecify Yes or No Ricen, etc.)	- 14. Rac Bla	ce - Americ	can Indian, etc.
21215-0020	ours after ral', or I	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 N If Yes, Give Year or Dates:	lo		1 □ Yes 2		Specify:			Specil	fy:	TTE
2	72 h natu	Completed	15. Decedent's E (Specify only highest g	Educetion rede completed)	16	Se. Deced	dent's Usual kind of work	Occup	petion during most	of work	rina	16b. Kind of B		
2	be filed within tal Hygiana. d other than "	du	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life.	DO NOT use	retire	d)	0. 110111	9			
	ygiar ygiar yer th	S					HOME	MAY					HOME	3
Suc	d out	Be	17. Father's Name (First, Middle, Las	•					18. Mothe	r's Nam	e (First, Middle,	Maiden Sumer		
Maryland	2 should be filed withir and Mantal Hygiana. Is marked other than aumatic evant, the Ma	2	HENRY		LOBE				AMEI	JIA			BACH	RACH
Jai	2 sh and ls m		19a. Informent's Name/Relationship (Type, Print)  ALFRED MOSES (SON)  19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip  1201 PENNSYLVANIA AVE. WASHINGTON, DC 2									Code)		
	1 and Haalth em 27		ALFRED MOSES (SON)  1201 PENNSYLVANIA AVE. WASHINGTON, DC 20044  20b. Plece of Disposition (Name of Disposition (Name of Disposition)  20b. Plece of Disposition (Name of Disposition)  Date 20c. Location - City or Town, State										20044	
Baltimore,	permit. Pages 1 and Department of Haalth Important: If Item 27 any injury or other tr once.		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremetion 3 l	☐Removal from State					ce)	ì	Date	20c. Location	- City or To	own, State
E	man man ant:		4 ☐ Donetion 5 ☐ Other (Spec		BALTI	MORE	HEBRI	€W	7	7/13	/97	BALTIM	ORE,	MD
a	permit. Pages Department of H important: If ite any injury or of once.		21. Signature of Lineral Service Lice	nsee	1				es of Fecility	W.				
Ш	20 E # 9		1. Signature of Luneral Service Licensee  22. Name end Address of Fecility  SOL LEVINSON & BROS., INC.  8900 Reisterstown Road Pikesville, MD 21208											
	ш.,		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused	the death. D	o not ent	er the mode	of dyir	ng, such es	cardiec	or respiretory e	rrest,	27 110	Approximete fntervel Between
	/Medical Examiner	iner	Immediete Cause (Finel disease or condition resulting in death)  e. Respiratory Failure  Due to (or es e consequence of):										- 4	
Box 68760,	law requiras that tha daath certificate be axecuted as been signed by the attanding physician and 2 should be detached for use as the bunal-transit	In/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	С	Due to (or es	e conseq	uence of):							
	a daath the atta hed for	Physician/	Pert II. Other eignificent conditione	contributing to death bu	t not resulting	in the u	nderlying cau	use giv	ren in Pert I.		23b. Dld	tobecco uee co	entribute t	o the cause of death
<u>Р</u>	hat tha de ed by the detached	hy		To another the second					•				3 □ Pro	
	as tha igned be de	by F	OBSTRUCTIV	12, 14 9 PM	RTR	OPI	FIC C	SHK	DIVIN	1091	97749			, ,
Records,	aw require ts been si 2 should l	Completed	KYPHOSCO	410515								en eutopsy rmed?	ev	ere eutopsy findings reilable prior to empletion of ceuse deeth?
ď	The law ata has page 2	Eo									10	res 2 No		Yes 2 No
ā	ician: The certificata rector, pag	BeC	25. Was case referred to medical					_	26 Plece	of Deat	th (Check only o			3100 2310
of Vital	Z w D	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 ER/0	Outnatien	t 3 DOA	Oth	or:		ome 5 Resid		ner (Snecil	6/1
	iling Ph J. After th funaral		27. Manner of Deeth  1 Naturel 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Dey		. Time of Injury		c. Injur Wor			28d. Describe I			<i>y</i> /
Division	Attendar deat ector:	Certification:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		ry - At home, (Specify)	farm, str	eet, factory,	office			28f. Location (S City or Tox	Street end Numi vn, State)	ber or Rure	el Route Number,
/	Hepital or 24 hours afte Funeral Dir Helely Nied in	edical C	29a. Certifier 1 Certifying Place (Check only one) 2 Medicel Exa	hyelcian: To the best of miner: On the besis of and manner stet	examination e	ge, death end/or Inv	occurred et restigetion, le	the tin	ne, dete end plnion, deat	d plece, h occur	end due to the red et the time,	ceuse(s) end m date end place,	enner es s end due t	iteted. the ceuse(s)
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	1		30. Name end eddress of person who	completed series of de	Mr. 140-00	V (T)	Drint)	L	118	116		17	1//	
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ļ.	Sta	ate	31. Dete filed (Month, Day, Year)	32 Dogistra	r's Signature	55	rails	KO	ad, #	7/6	Luth	erville	170	21073
	Regist		.111 1 5 1997	gulia Davidson	n-Mande	00								

JUL 1 5 1997

State of Maryland / Department of Health and Mental Hygiene

21389

						Cer	tificate d	of Death		F	Reg. No.		Sea 1	000
	Discontact		1. Decedent's Name (First, Middle, Li	ast)						2. Dete of Dee	eth Day	Year	3. Time	e of Death
	Physici /Medi		MARIE	T.	MAI	RLOW	Æ			July 12		1001	9:4	10 AM
	Examir		4a. Fecllity Name (If not institution, gi	ve street end number)				4b. City, To	wn, or Lo	cation of Death	4c. County	of Deeth		
			Good Samaritan I	Hospita1				Ba1	timo	re		N/A		
	Funeral				e (In yrs. last bir	thday)	If Under 1 Ye			8. Date of Birtl	h		place (Stet	te or Foreign
	Director		214-03-4501 Usual Residence of Decedent	1□M 2 <b>⊠</b> F	76	Yrs.	Months De	eys Hours	Min.	July 13	, Year) , 1920	Cour	ntry) Md	
	/anyland	5	10a. State 10b. County		10c. City, Tow		cation					1		e City Limits
	28a-	Director	Md. Baltin	nore	Tows	son	101 71 0	10						
	E S						10f. Zip Coo				10g. Citizen of		itry?	
	ath v	ia	112 Beech View				2128	86			USA			
	s 1 and 2 should be filed within 72 hours after death with the Maryland t Health and Mantal Hygiena. I then 27 is marked other than "natural", or items 23a or 28a-f show then traumatic event, the Medical Examinat must be notified at	by Funeral	11. Maritel Status  1 Never Married 2 Married  3 Widowed 4 Divorcad	12. Was Decedent Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:		If	Yes, specify (	of Hispanlc Ori Cuban, Mexicar No Specify:	n, Puerto	acify Yes or No- Rican, etc.)		ck, White,		
	2 ho	ted	15. Decedent's E	ducation	16a.	Deced	ent's Usuel Oc	cupetion			16b. Kind of B			
1	within 7 ena. than "n	Completed	(Specify only highest gr Elementary/Secondery (0-12)	eae com <i>pletea)</i> College (1-4or 5	i+)	life. D	OO NOT use re	one during mos stired)	it of worki	ng				
i	d with giena.	5		2		ome	Maker				Own H	lome		
	al Hygid I other vent,	Be (	17. Fether's Neme (First, Middle, Las	")				18. Mothe	er's Name	(First, Middle,	Meiden Sumen	ne)		
	should be and Mantal s markad o umatic eve	ToE	William	I	Dauber			Mary	,		Se	ufer	t	
	ond N	-	19a. Informant's Name/Relationship			. Mailin	g Address (Str			el Route Numbe	r, City or Town,	Stete, Zip	Code)	
	alth ar 27 is or trau		Mr. Albert T. Man	clowe .Tr	/snouse	112	Beech	Wiew C	'+ m	OWSOn	Md 212	86		
	os 1 and 3 of Health Item 27 i		20a. Method of Disposition	1000	20b. Place of	Dispos	sition (Neme o	1		Date	20c. Location		own, State	
	Pages net of I int: If Ite		1 Burial 2 Cremetion 3				etory or other							
	rtme rtant		4 □ Donation 5 ☒ Other (Speci		nt Dular					/15/97	Timoniu	m, Mo	d.	
	permit. Pages Department of important: If It any Injury or o		21. Signature of Funeral Service Lice	A D	~	Ru	ck Tow		eral	Home,				
			23e. Pert1. Enter the disease, or con shock, or heart feilure. List only	plications that caused	the death. Do								Approxin	nate
	Physician		shock, or heart fellure. List only	one ceuse on each li	10.							į	Interval E Onset an	Between nd Death
٠	/Medical		Immediate Ceuse (Final	e. Pres		1	74444	1.		/-		į.	7411	1. te
	Examiner		disease or condition resulting in death)	e. The	sumea		myo	earn		Ma	coson		moor.	(100)
		<u></u>		4	Due to (or as a	consequ	uence of):			,				
	sit ed	를		b. Ayp	enli	Dio	dem	à						
	and and I-trar	Examiner	Sequentially list conditions, if any, leading to immediate	/ 1	Due to (or as a	consequ	uenca of):							
	eath certificata be axecuted attanding physician and I for usa as the burial-transit	E	cause. Enter Underlying	0										
	ata b hysic the b	edicai	Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or as a	consequ	uence of):							
	diffica ast	Med	Tooking in doubly East									1		
	n cel	20		d								1		
	deat d for	lois	Part II. Other aignificant conditions	contributing to death by	it not resulting la	n the un	dedvino cause	oiven In Part I	ı	23b Did t	obecco use co	ntribute t	o the caus	ee of death?
	that the death	Physician	0 .		,					1 🗆 1	1			Unknow
	as that igned to be det	by P	Renal fail	me,	uype	re	nsion	~,		'''	res 21 (No	3_110	oably 4	Onknow
	The law requires that the death ate has been signed by the atter paga 2 should be detached for		DL D.	une, e aii w	//					24a. Was	en eutopsy	24b. W	ere eutop:	sy findings
	v require been si should	Completed	ofstructu	e an w	any d	1. se	ase				med?	ev	eilable prid	or to
	nas a 2	ldu			7							of	death?	
		Co								1 🗆 Y	es 2 No	1[	□Yes 2	2□ No
	Physician: The lave this certificate has rai director, paga 2	Be	25. Was case referred to medical					26. Plece	e of Death	(Check only o	ne)			
	ysic s ce dire	2	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatie	nt 2□ER/Ou	Itpetient	3□ DOA	Other: 4 Nu	ursing Ho	me 5 Resid	lence 6 A 6th	er (Specil	y Su	bacut
d	rai e		27. Manner of Death	28a. Date of Injur		Time of	28c. l	njury at		28d. Describe h		red		
Ρ,	25	atio	Natural 5 Pending 2 Accident investigation	n 7-170	7	njury		Work? 1 ☐ Yes 2 ☐	No					
9	F 96 1	fica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Pleca of Inju	ury - At home, fa	ırm. stre	et, factory, off	ice		28f. Location (S	Street end Num!	per or Rure	al Route N	lumber.
-	o a la	Certification:	4 Homicide	building, etc	. (Specify)					City or Tow	m, Stete)			
7	0 0 m		29a. Certifier 1 CertifyIng Pl	voicies. To the heat	of many languages	dooth	and the state of t	- 41	el interne	and due to the				
	To the Hospir within 24 hou To the Funer completely fill	edicai	(Check only one)	yeician: To the best on miner: On the basis of	examination an	d/or inv	estigation, in n	e ume, date en ny opinion, dea	ith occurr	ed et the time, o	date end pleca,	end due to	teted. o the ceus	e(s)
	thin	Med	0.10)	end manner sta	ted.		T							
١	5 1 × 0	_	29b. Signature and fitte of certifier	& Cla	26	MI	Ds.	ense number	Va		29d. Dete signe			,
	,		Howard	Jun		. [	יי	いろひ	TU	Blud	7-1:	2-9	7	
			30. Name and eddress of person who	completed cause of d	eath (Item 23e)	(Type, F	Print)				1 1	01	1	
	$\varphi$		H. Heine		0/	101	- 6 A	Lauce	2	Blud	Ba	10	21	239

Registrar

97-3825-510

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

1 ☐ Yes 2 ☐ No

	CHARI MURRA		3	State of Maryl	and / De	epartment of Certificate of	Health and Month		giene 9	7 21	390
	Physici /Medio Examin	al	1. Decedent's Name (First, Middla, La, Charles Follows) 4a. Fecility Neme (If not institution, giv. 3512 LUCILLE A)	SWARd a street and number)	Mui	RRAY	4b. City, Town, or L		11 1 4c. County	997 7:	Sime of Death
	Funeral Director		5. Social Security Number 6. S  2/2-34-6563 1  Usual Residence of Decedent	7. Age (In )	yrs. last birtho	Months Day	ar If Under 24 Hrs.	8. Date of Birth (Month, Day	Year) 13 1937		Stata or Foraign
	e Maryland 8a-f show	ctor	10a. State 10b. County MARY and None	R	City, Town o	r Location					side City Llmits
	th with the 23a or 2	Funeral Director	35/2 Lucille 1	ME		10f. Zip Code	е		10g. Citizen of V		
020	be filed within 72 hours efter death with the Marylan Hydione.  Ad other than "natural", or frems 23a or 28a-f show event, the Medical Examiner ment be notified at	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates: 19.		I3. Was Decedent of If Yes, specify C	of Hispanic Origin? (Sp uban, Mexican, Puerto No Specify:	ecify Yes or No- Ricen, etc.)	14. Race Blace	- American Inc k, White, etc.	ian,
21215-0	filed within 72 ho Hygiene. ther then "netul ent, the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	Lucation da com <i>platad)</i> College (1-4or 5+)	(6)	ecedent's Usual Occiliva kind of work doise DO NOT usa rat	cupation na during most of work irad)	ing	16b. Kind of Bu	, ,	Inment
Baltimore, Maryland 21215-0020	2 should be filed within 72 hours effer death with the Maryland and Mental Hygiene. I stranked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	To Be C	17. Father's Name (First, Middle, Last)  PRICE MUK,  199, Informant's Name/Relatipoship (1)	nny	19b. M	lailing Address /Stre	18. Mother's Nam DoRoithy set and Number or Rui	€. 10.	hite	e)	
e, Ma	ss 1 end 2 should of Health end Mer itam 27 is merke other traumetic		COROLYN Rice		591		ing bird Li		kinbir	, md.	21045
imor	Peges ment of H ant: If its ury or of		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Spacify	Removal from State		crematory or other p	place)	15/97	20c. Location -	City or Town, S	nd
Ball	permit. Peges Depertment of important: If it any injury or once.		24 Signature of Funeral Service Ligen	Ellan		3405 W		21229		al Ser	vice
F	hysician		23a Part Enlar of disease, or companion, or halp feilure. List only			enter the mode of o	tying, such as cardiac			Appro Inten Onse	oximate val Between at and Death
	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting In death)	Arteriosc]		ic Cardi	ovascula	r Dise	ase		
,	ete be executed nysician end the buriel-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	b. Due to	o (or as a con	sequence of):					
		_	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to	o (or es a con	sequence of):					
s, P.O. Box	w requires that the death certifice is been signed by the ettending ph 2 should be deteched for use es the	by Physician/Med	Part II. Other significent conditions of	ontributing to death but not	resulting in th	e underlying cause	given in Part I.		obacco use cor ∕es 2□ No		ausa of death?
scords,	sw requires is been sign 2 should be	pleted b						24a. Was a perfor	an autopsy med? ECTION	24b. Were au available completi of death	prior to on of ceuse

Division of Vital Rec

Comple Be

page 2 s Medical Certification: To

25. Was case referred to medical examiner?

i Hospital or Attending Physician: The lew 24 hours efter death.

Funeral Diractor: After this certificate has t filled in by the funeral director,

1 Naturel
2 ☐ Accident 3 Suicide 4 - Homicide 29a. Certifier

1⊠Yes 2□ No

27. Manner of Deeth

(Check only one)

6 Could not be determined

5 Pending Investigation

28a. Date of Injury (Month, Dey Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 ☐ Nursing Home 5 💆 Residence 6 ☐ Other (Specify)

28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

26. Place of Death (Check only ona)

1 Yes 2 No

Location (Straat and Number or Rurel Routa Number, City or Town, Stata)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature end title of certifier

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year)

JULY 12,1997

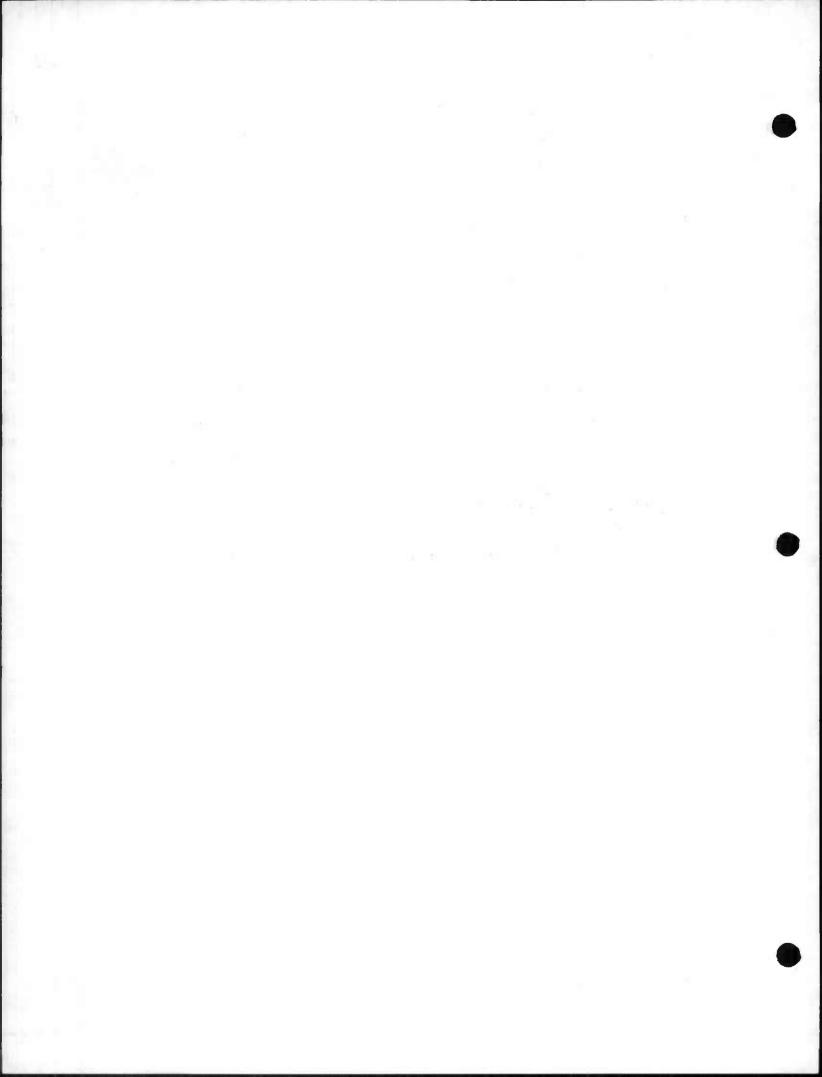
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

Margarita Korell M.D.

111 Penn Street, Baltimore, Maryland 21201

State Registrar





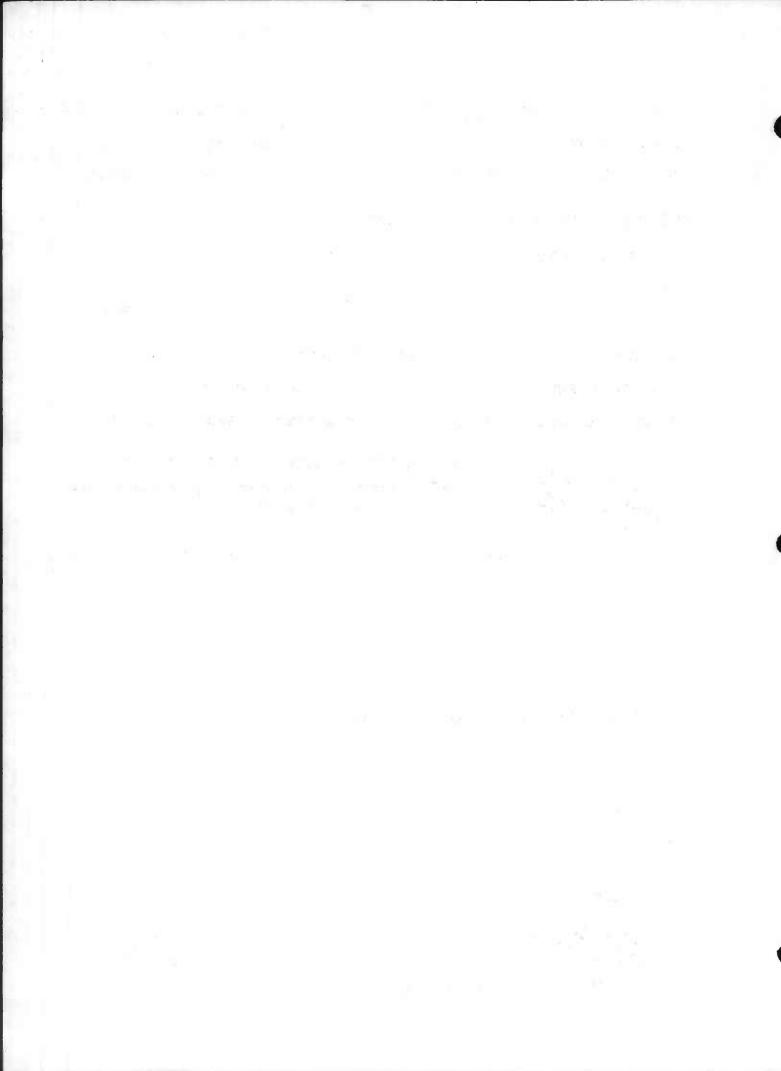
State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Month Year 10:00 P.M. ANNE MAE MORRIS JULY 9, 1997 /Medical 4a. Facility Name (If not institution, giva street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** GENSIS LONG GREEN BALTIMORE CITY n/a 5. Social Security Number If Undar 1 Yaar If Under 24 Hrs. Hours Min. 8. Data of Birth (Month, Dey, Year) 5/29/03 7. Aga (In yrs. lest birthdey) Birthplace (Stete or Foraign Country) **Funeral** Deys 1 ☐ M 2 € F 212-10-3715 Yrs. 94 Director MARYLAND Usuel Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND BALTIMORE TOWSON 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò 6915 LACHLAN CIRCLE items 23a 21239 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) Rece - Amarican Indian, Bleck, White, atc. 72 hours aftar 1 XNevar Married 2 ☐ Married 1 Yas 2 No If Yes, Give Year or Dates: ò Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", WHITE Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry should be filed within 7 and Mantal Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) 12th GRADE INSURANCE AGENT **INSURANCE** permit. Pegas 1 and 2 should be file Department of Haalth end Mantal Hy Important: if Item 27 is marked other any injury or other traumatic event ones. 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnema) CHARLES MORRIS **EMMA** KELLER 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) GEORGE T. REICHARD NEPHEW 6915 LACHLAN CIRCLE TOWSON, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 X Buriel 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) LORRAINE PARK CEMETERY 7/14/97 WOODLAWN, MD 21. Signeture of Funeral Service Treasure 22. Name end Address of Fecility JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Enter the disaasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or have failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final disaase or condition resulting in death) Examiner Examiner The law requires thet the death cartificete be assecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest and Due to (or es e consequença of): bunal-P.O. Box 68760, Physician/Medical tha Due to (or es e consequance of) attanding i signed by the a Part II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use centribute to the cause of death? deficiency 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings eveileble prior to completion of causa of deeth? Completed 24a. Wes en eutopsy performed? pega 2 2 12 No certificate 1 Yes 1 ☐ Yes 2 No Vital Be 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 ☐ Yes 21 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA ō 28a. Date of Injury (Month, Dey Year) 27. Mann of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 Tyes 2 No investigation 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, streat, factory, offica building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours
To the Funerall complately filled Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end placa, end dua to the cause(s) and menner stated. 29a. Certifier 29d. Date signed (Mogeth, Day, Year) 29b. Signetura ap 29c. License number 1 30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) Charles St Baltimore, MD 4300 W. 155 31. Dete filed (Month, Day, Year)
JUL 1 5 1997 32 Registrer's Signature State

Wandow , andelle

**DHMH 16 Rev 6/95** 

Registrar



97-3766-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. wlc State of Maryland / Department of Health and Mental Hygiene 21392 DONALD J. Items: 23a part I,27,28a-f per MEO G-749 7/23/ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month 9,1997 July 1200p Donald James Morsell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MD SHCOK TRAUMA If Under 1 Yeer If Under 24 Hrs.
Hours Min. BALTIMORE 6. Sex X□ M 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Days Yrs Director 214-84-1266 MAR 14, 1960 Maryland Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 7 is merked other than "natural", or liems 23s or 28s-f show fraumatic event, it a Modical Examinal must be notified at MD Anne Arundel Glen Burnie 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 Crain Court Circle, Apt. 2B death Funeral 21061 USA 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within: Deportment of Health and Mental hygiene. Important: If Item 27 is merked other than "I any Injury or other traumatic event, it a Med Commercial Elementary/Secondary (0-12) College (1-4or 5+) Construction 12 Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Donald Irvin Morsell Helen May Leisner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa M. Morsell/Wife 206 Crain Ct. Circle, Apt. 2B Glen Burnie, MD21061 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 7/11/97 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation Society of Maryland, Inc. Dawn F. McDonald onald 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) GUNSHOT WOUND WITH COMPLICATIONS **Examiner** Due to (or es a consequence of) Examiner the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as e consequence of): Box 68760 2 Physician/Medical Due to (or es a consequence of) ò P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Dld tobacco use contribute to the cause of death? signed by t 1 Yes 2/25No 3 Probably 4 □ Unknown Records, ò 24b. Were autopsy findings aveileble prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen this certificete hes 1 Yes 2 No 1 Yes 2 No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2XXR/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1XIXes 2□ No 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1 Natural Injury

I Director Afterthis of in by the funerel di or Artisticing Jivision

5 Pending investigation 1 ☐ Yes XX No 2 Accident 6/19/97 11:49 subject was shot 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State)8005 Nolpark Court 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4XX Homicide

29a Certifie

Medical

parking lot Glen Burnie, Maryland 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ZXI Medical Examiner: On the basis of examination and/or investigetion, In my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier

29c. License number 29d. Date signed (Month, Dey, Year)

O.C.M.E.

July 10, 1997

30. Name and address of person was completed cause of death (Item 23a) (Type, Print)

Chute no Dennis 31. Date filed (Month, Day, Year) JUL 1 5 1997

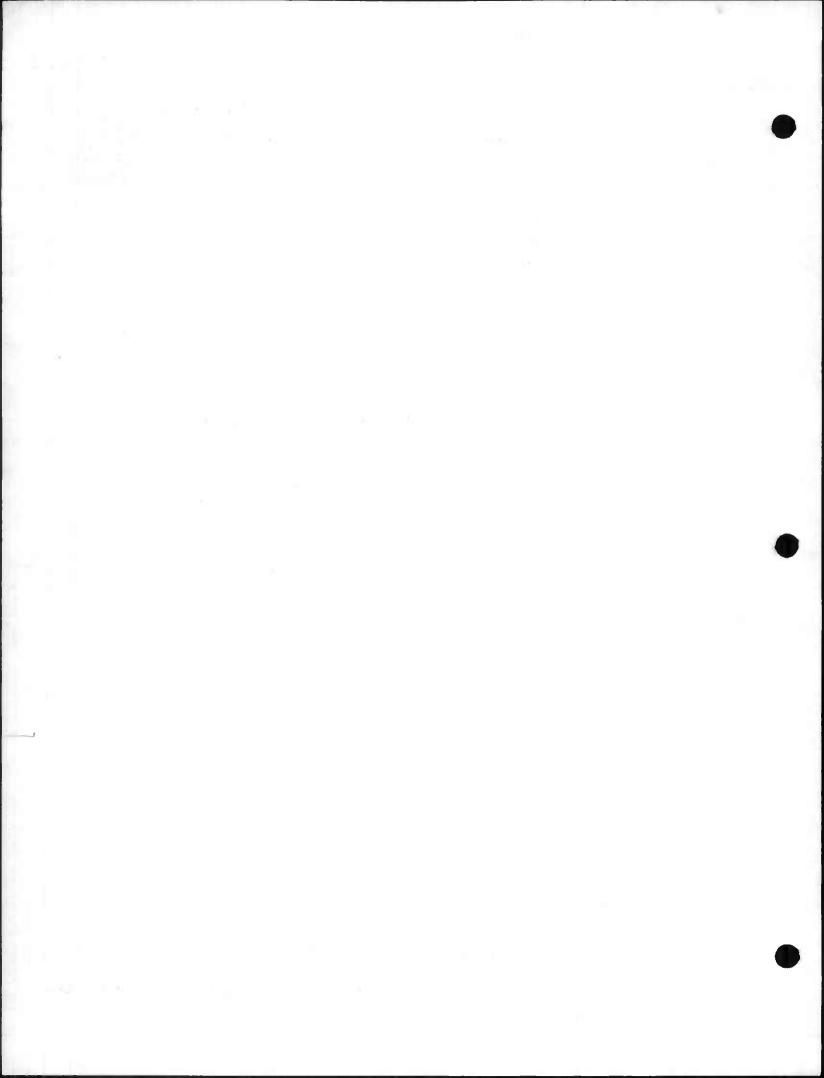
111 Penn Street, Baltimore, Maryland 21201

State Registrar

24 hours

To the within 2

Hospital



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Daath 3. Tima of Deeth Month **Physician** 26 4102PM JUNE /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Locetion of Daeth 4c. County of Death Examiner BALTIMORE, HOSPITAL AGNES MA If Undar 1 Yaar If Undar 24 Hrs.
Months Deys Hours Min. 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Deys 150 M 2□ F Months O Yrs. 217-49-0961 Director Usual Rasidence of Decedant the Maryland 10a, Stata 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiona. Important: if Item 27 is merked other than "netural; or Items 23a or 28a-1 show any Injury or other fraumatic event, the Medical Examiner must be notified as any Injury or other fraumatic event, the Medical Examiner must be notified as Boltimore Marylork 1 Yes 2 No Director 10e. Street and Numbe 10f. Zip Coda 10g. Citizan of What Country? USA 12. Was Decedant Ever In U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or Noif Yes, specify Culfan, Mexicen, Puarto Ricen, etc.) 11. Marital Status 14. Rece - American Indian, Black, Whita, etc. 1 Navar Married 2 Married Specify: Blac 3altimore, Maryland 21215-0020 1□ Yes 2☑ No þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Giva kind of work done duning most of working lifta. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) College (1-4or 5+) 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nema (First, Middla, Maidan Surname) tor 110 19a. Informent's Name/Ralationship (Type, Pnint) 19b. Mailing, Address (Street and Number or Ryral Route Number, City or Town, State, Zip Coda) Willie 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Date 20c. Location - City or Town, Steta patary cramatory or other place) 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licensee 192 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Batween Onsat and Death Physician Immediata Ceuse (Final disaase or condition resulting in daath) /Medical ORGAN FAILURE WEELS . MULTISYSTEM Examiner Due to (or es e consequance of): Examiner PREMATURI NEERS GI XTREME physician and the burial-transil Sequantially list conditions, if any, laading to immadiata cause. Enter Undarfying Cause (Disaase or injury that initiated evants resulting in daath) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 88 94 Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 | Yes 2 | No 3 | Probably 4 | Unknown þ 24b. Wara autopsy findings evellabla prior to complation of causa of death? 24a. Was an autopsy performed? Completed certificate has 2 No 1 Yas 1 ☐ Yes 2 ☐ No Be 25. Wes case rafarred to medical 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No 2 1 🖪 Inpatiant 2 ER/Outpatiant 3□ DOA 27. Manner of Death 1 Matural 28d. Dascribe how Injury occurred After 5 Pending invastigation 1 Yas 2 🗌 No e Hoppital or Attendi 24 Fours after death a Fugeral Director: A 2 Accident 6 Could not be datermined 3 Suicida 28f. Location (Straet and Number or Rural Route Number, City or Town, State) Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowladge, death occurred at tha tima, data and plece, end dua to tha causa(s) and manner as steted.

2 Medicel Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, data and place, and dua to the cause(s) and manner stated. (Check only one) 29b. Signatyfa and titla of certifiar 29c. License numbar 29d. Data signad (Month, Day, Yaar) 30. Neme end addrass of person who complated cause of deeth (Itam 23a) (Typa, Print) BIRENBAUN BATIMORE, 100 CATON AVE.

State Registrar

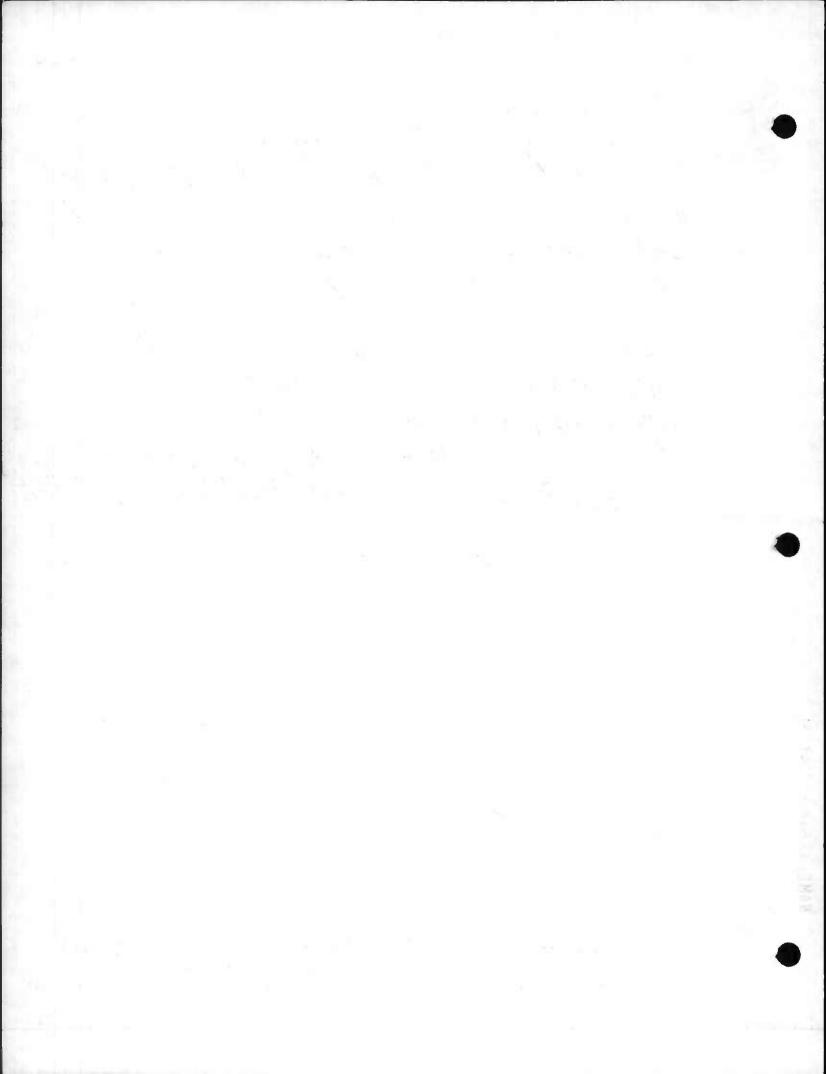
JUL 1 5 1997

31. Data filed (Month, Day, Year)

32. Registrer's Signatura

Julia Javidson-Randelle

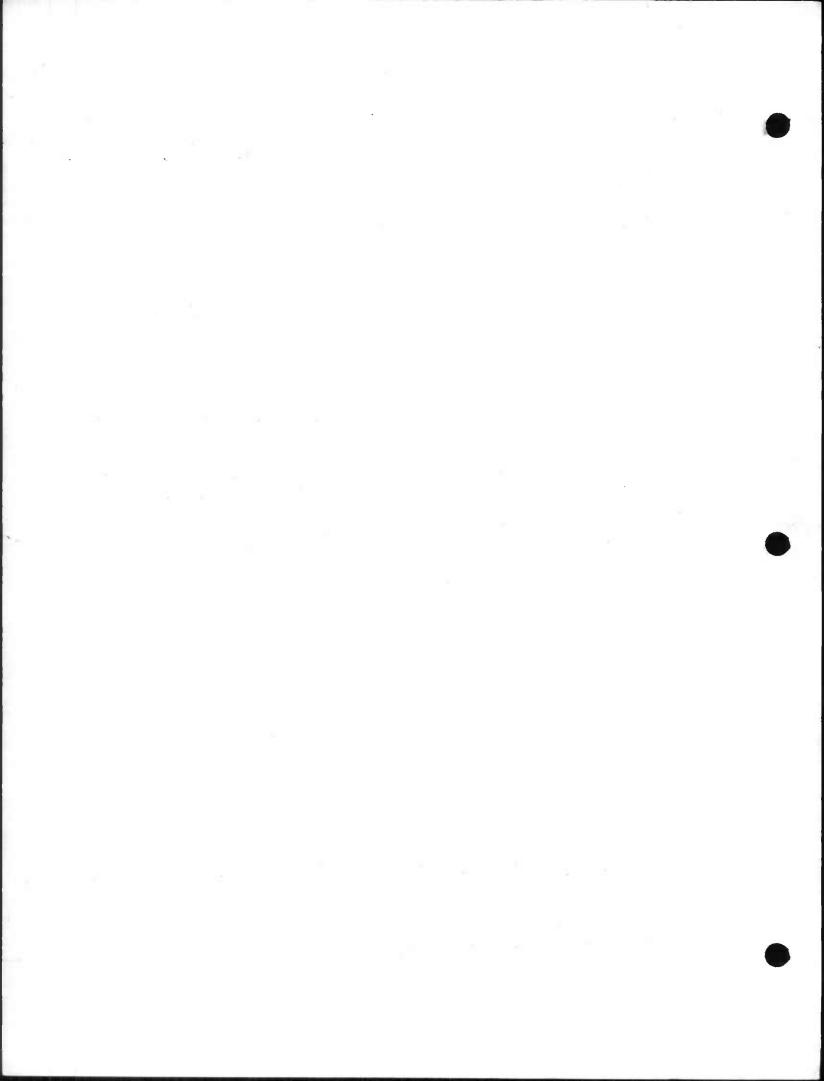
NAME, ISAIANA MCKOU



DHMH-16 Rav 1/89

		nit. Pages 1, 2, 3 should
0200-5121	or attending physician.	certificant has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
BALLIMORE, MARYLAND 21215-0020	resolute. The law requires that the death certificate be executed within 24 from the thath. Page 6 may be retained by the hospital or attending physician.	e 5 should be detached for
BALLIMORE	in thath. Page 6 may b	the funeral director, pag
•	within 24 hours ath	mpletely filled in by t
PECURDS, P.O. BOX 68/60	ertificate be executed	ing physician and co
COMDS, P.	uires that the death of	signed by the attend
P VII AL KE	PUCKAN The law requ	certificate has been
DIVISION	OR ATJENDING BY	DIRECTOR: AND IN
	TO THE HOSPITAL	TO THE FUNERAL

	•	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
		1. DECEDENT'S NAME (First, Middle, Last)		Ma	A A O mod la			2. DATE OF DEATH MONTH DAY 97 430 M M M M M M M M M M M M M M M M M M M				
	ļ	4. SOCIAL SECURITY NUMBER 230 56 7955	.d		IF UNDER 1 YEAR IF UNDER ONTHS DAYS HOURS	24 HRS. 7. DAT	TE OF BIRTH (Inth Day, Year)	6. B	Ountry) Culoa	7		
GTOB		99. FACILITY NAME (If not institution, give st 35 HOWAN	ireet and number)	e	EI Kton	M OF DEATH	)	9c. COUNTY C				
- H	DIRE	100. STATE 10b. COUNTY	ecil		TOWN OR LOCATION				10d. INSIDE CITY LIMITS? 1 YES 2 XNO	o ween Oeath		
EINERA		35 Home	nurst L	ane	101. ZIP CODE	921		10g. CITIZEN	of what country?			
RY FIIN	- 11	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	13. WAS DECENDENT OF				RACE — American Indian, Black, White, etc. Specify: White			
PIETED		15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondery (0-12)		18e. DECEDENT'S US (Give kind of wor life. Do NOT use	rk done during most of working	9	66. KIND OF BUS					
once.		17, FATHER'S NAME (First, Middle, Last)					t, Middle, Malden			DINGS USE		
11 m		Jose March y Barcelo  Clara Alvarez-Munoz  190. INFORMANT'S NAME (Type/Print)  190. MAILING AGORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
be notified	2	Evelia M. C. M	arch/wife	35 Ho	mehurst Lane	e, Elkt	on, Mar	yland 2	21921			
must		20e. METHOO OF DISPOSITION  1 Buriel 2 Cremation 3 Rem  4 Denution Dither (Specify)		.PLACE AND DATE OF etery, cremetory or othe	DISPOSITION (Name of place)	ומ	ATE 20c. LO	CATION — City	or Town, State			
examiner		Ronald S. Wade, Director State Anatomy Board, 655 W. Baltimore St.										
or removal.	Z	23. PART I. Enter the diseases, or called the second follows	complications that caused List only one cause on ea		Baltimore tenter the mode of dyi				Approximete	o ween Oeath		
tion, or		IMMEDIATE CAUSE (Final disease or condition resulting in death)	Nesto,	valuy	Fallu	e			intervel Between Onset and De			
a denocarcinima of Lyng									3 yv.	5		
Hygiene prior to buna r other traumatic		if sny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	c. SM.	O/C/V	4	0	/					
F 9 1	i II	that initieted events resulting in deeth) LAST  DUE TO (OR AS A CONSEQUENCE OF):										
any injury.		PART II. Other significant condition	s contributing to deeth b	ut not resulting in	the underlying cause g	liven in Part i.	24a. WAS AN PERFOR	RMED?	24b. WERE AUTOPSY FINDIN AVAILABLE PRIOR TO COMPLETION OF CAUS DF DEATH?			
5 4 5												
State Dept.		25. WAS CASE REFERRED TO MEDICAL  28. PLACE OF DEATH (Check only one)  EXAMINER?  HOSPITAL:  OTHER:										
HVS HVS		1 TYES 2 NO  27. MANNER OF DEATH	1 Inpatient 2 ER/Outp	patient 3 DOA 4	OF 28c. INJURY AT		ther (Specify)	NJURY OCCURE	20	_		
		1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUI	M 1 TYES 2	NO NO						
200		3 Suicide 8 Could not be 4 Homicide detarmined  28e. PLACE OF INJURY — At home, ferm, street, tactory, office building, etc. (Specify)  28f. LOCATION (Street and Number or Rural Roucity or Town, State)										
후 후 등		29e. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) and manner as stated,  2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) end menner se stated.										
IMPORTANT: IL I		29b. SIGNATURE AND TITLE OF CERTIFIE	1 See	-	29c. LICE	AZ)	7 X	29d. DATE SIG	GNED (Month, Pay, Year)			
2 ₹	2	30. NAME AND ADDRESS OF PERSON W	O COMPLETED CAUSE OF SE	WTH (ITEM 27) (Type, F	W. High	St-St	9-103	3-8 OK	ton My 21	921		
		31. OATE PILED (Month, Day, Year)  JUL 1 5 1997	Julia Davidam	Agenda 02					, , ,	-		



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath **Physician** Month 1510P MEISEL ANNA 1997 JULY /Medical 4a. Fecility Nema (If not institution, giva street and numbar) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY 5. Social Securify Number If Under 1 Yaar if Undar 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) 6. Sax 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** 1 □ M 2 🔀 F 213-10-6010 Yrs. 92 Director Nov. 17, 1904 Maryland Usual Rasidance of Decedant 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Maryland Rockville Montgomery 1 Tyes 2K No Director 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 20850 U.S.A. 9701 Viers Drive 11. Marital Status unknown 12. Was Decadant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Bleck, White, etc. 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Datas: 1 ☐ Navar Married 2 ☐ Marriad 1 ☐ Yas 2 ☑ No Spacify: White Specify: 3 ☐ Widowad 4 ☐ Divorcad 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sewing Machine Operator Private 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) 3.2 should be fill h and Mental H is marked oth Joshua Wenzel Augusta Wenzel 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, Stata, Zip Coda) permit. Pages 1 and 2 sh Department of Health and Important; if them 27 is in any injury or other traum once. Treva Ann Bergeron/daughter 1095 Montclare Drive, Sykesville, MD 21784 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4€ Donation 5 Othar (Specify) 21. Signature of Fuheral Service Licensee Ronald Made, Director State Anatomy Board, 655 W. Baltimore Street Lalle Baltimore, Maryland 21201 23a. Pall 1. Entar tha disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, which, or heart failure. List only one cause on each line. Physician /Medicai Immediata Causa (Final disease or condition resulting in daath) a. Acute Congestive Heart failure
Due to (or as e consequanca of): 30 mins **Examiner** Examiner b. Arterioscleratic Coronary Artery Disease 40 years
Dua to (or es e consequence of): Sequenfially list conditions, if eny, leading to immadiata causa. Entar Underlying Causa (Disaasa or Injury Calcification Box 68760 Physician/Medical that initiated evants rasulting in daath) Last Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Upper gastrointestinal bleeding, duodenal Division of Vital Records, 24b. Wara autopsy findings availabla prior to complation of causa of death? 24e. Wes en autopsy Completed arteriovenous malformation, diabetes meilitis 25. Was casa rafarrad to medical examiner? 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐ No or Attending Physician: efter deeth. Director: After this certific 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending invastigation 1 Tas 2 No 2 Accident 6 ☐ Could not be 3 Suicida 28a. Place of Injury - At home, farm, sfraat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 I Homicida Hospital of 24 hours ele
 Funeral D 29a. Cartifiar 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha time, data end plece, end due to the ceusa(s) end manner as steted. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29b. Signature and Altie of ceptiler 29c. License number 29d. Date signed (Month, Day, Yeer) elum mol 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

Schemm. MD, 9701 Viers Drive, Rockville MD 20850

Registrar

31. Data filad (Month, Day, Yaar)

50 Y 10 P 10 St 12 

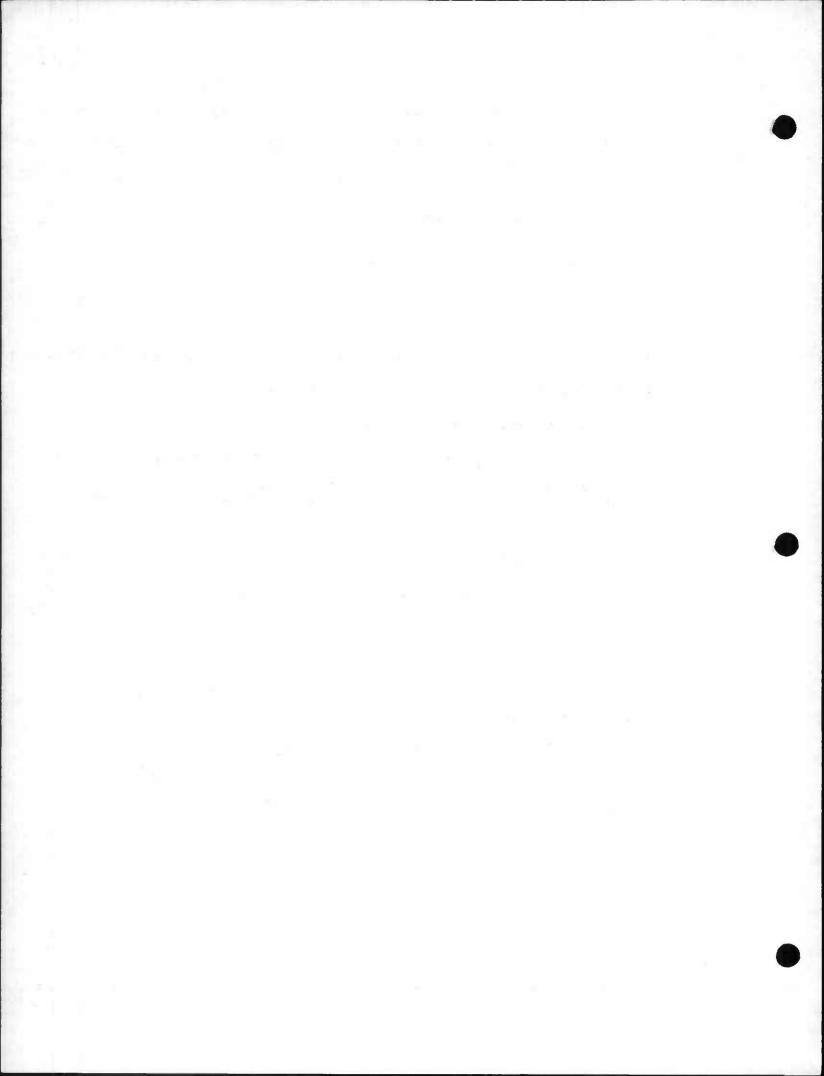
State of Maryland / Department of Health and Mental Hygiene 97 2 1 3 9 6

							Cert	ificate of	Death		Reg. No.				
			1. Decedent's Nan	ne (First, Middla, La	ist)					2. Dete of D	eeth		3. Time of Death		
	Physic /Medi		BRIT	ANNA	MICHEL	LE	N	ETTLE	S	TULY	Dey 13	Yaar 1997	902 AM		
	Exami		4a. Fecility Nama	(If not institution, giv	ra street end number)				4b. City, Town,	or Location of Dea					
1			The !	Johns He	opkins Hos	pital			Baltim	ore city					
	Funeral		5. Social Security		Sex 7. Age	(In yrs. last bi		If Undar 1 Year Months Days		Hrs. 8. Data of Bi	rth ey, Yeer) 1995	9. Birthp	lece (Stete or Foraign		
1	Director		219-43-9	004	ILIM ZLAF	2	Yrs.			Feb. 6	, 1995		yland		
	and *		Usuel Residenca o	10b. County		10c. City, Tow	m or Loc	ation					Od. Inside City Limits		
	Aaryli f sho	5									1 ☐ Yes 2 ☑ No				
	the the 28a-	8	10e. Street end Nu		uidei	rt. M	eaue	10f. Zip Code			10g. Citizen of	Mhot Cour	41		
	with a or	ā		eslie Roa	od.			·	0755						
	s 1 end 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiena. If Health and Mental Hygiena. It has narked other than "netural", or items 23s or 28s-f show other traumstic event, the Medical Exerciter must be notified at	Funeral Director	11. Marital Status	CSIIC ROO	12. Was Decedent E	ver in U.S.	13 W			(Specify Vas or N	United	se - Americ			
0	r iter	F		riad 2 Married	Armed Forces?		13. Was Decedent of Hispanic Origin? (Sp If Yas, specify Cuben, Mexican, Puerto		ierto Rican, etc.)	Ble	Bleck, White, etc.				
21215-0020	urs a	by	3 Widowed		If Yes, Give 1 1 2 Year or Detes:			1 ☐ Yes 2 🕱 No Specify:			SpecifyWhite				
0	2 ho	E E		15. Decedent's Ed				lent's Usuel Occupetion			16b. Kind of Business/Industry				
21	B. B. R	Completed	Elementery/Sec	cify only highest gre ondary (0-12)	College (1-4or 5+)			(Give kind of work done during most of working life. DO NOT use retired)							
	or th	00	0				N/A					P/A			
pu	be file d oth event	Be	17. Fether's Name	(First, Middle, Last,	liddle, Last)			18. Mother		s Nema (First, Middle, Meiden Su		umame)			
<u>y</u>	2 should be filed with! and Mental Hygiena. Is marked other than aumatic event, the M	2	David C.	David C. Nettles				Deana M.			. Mitchel				
Maryland	and and ls me			leme/Relationship (			19b. Mailing Address (Street		et and Number or Rurel Route Num			Code)			
	es 1 end of Health I ftern 27 r other tr			Nettles/	Father				e Road,	Ft. Mead	e, MD 2	1755			
0			20a. Method of Dis		Removel from State	cemete	<ul> <li>Placa of Disposition (Neme of cemetery, cremetory or other ple</li> </ul>		,	Dete	20c. Location - City or Town, Stete				
Ë	nit. Pagentmen ortant: Injury			5 Other (Specif	Gr		reen Mount Crema		natory 7-16-97		7 Baltimore, MD		4D		
Baltimore,	permit. Page Depertment of Important: If any Injury or		21. Signatura of Fi	unoral astroicarLice	M		22. C7	Name and Addre	ess of Facility	Lohrman	n. P A				
ш	20 5 6 d		to	Duet To	Kunam	_						imore	, MD 21286		
			23a. Part1. Enter to shock, or hea	he disaasa, w com art failure. List only	plications that caused one couse on each line	the death. Do	not enter	the mode of dy	ing, such es card	liec or raspiratory	arrest,		Approximate Intervel Between		
4	Physician						_					1	Onset end Death		
	/Medical Examiner		Immediate Cause disease or condition	on	· YESPIV	aton	fai	lurz					2 WEEKS		
	LAUTITIO	L.	resulting in death)			Due to (or es e		ence of):					_		
	ed sit	Examiner			b. 189107	nella	DNG	monl	a			- 1	2 WEEKS		
	icata be axecuted physician end s the buriel-transit	xan	Sequentially list co	onditions, mmediete	J	Due to (or es e	consequ	ence of):							
9	be a siclan burie		Sequentially list co if eny, leeding to in cause. Enter Undo Ceuse (Diseese or thet initiated event	erlying r Injury	c. Para	influe	M72		Monta				2 WEEKS		
68760,	death certificata be axecuted attending physiclan end of for use as the buriel-transit	edical	resulting in deeth)	Lest		ue to (or es a		ence of):							
Box	eath certific attending pl	2			a MISTIC	y tos	15						one year		
	death atte	Ca	Pert fl. Other signi	ficant conditions o	ontributing to death but	not reculting i	n the und	lartvina causa ci	uon in Bort i	22h Dfd	tohacco use co	ntelbute to	the source of death?		
Ö.	MI	Physician/								23b. Dfd tobacco use contribute to the cause of deeth?  1 Pes 2 Dato 3 Probably 4 Unknown					
S, D	E AF	by F							_	To too Lights Collinson, All Children					
rd	N. J.									24a. Was	an eutopsy	24b. Wa	are autopsy findings		
200	S D S	e Completed								_ pen	performad?		completion of cause of deeth?		
Re	The law ate has b									167	1D/es 2□No		1 ☐ Yes 2 No		
ita			25. Was case referred to medical 26. Place of Deeth (C												
<b>f</b> V	Physician: rthis certific rral diractor,	To B	exeminer?	No	Hospital:	t 2 ER/O	utpatient	3 DOA ON	hor	g Homa 5 ☐ Ras		er (Snecifi	()		
Division of Vital Records,	Jing Ph h. After thi funeral		27. Menner of Deal		28e. Dete of Injury 28b. Time of 28c. Injury et 2						28d. Describe how injury occurred				
io	Attending ir deeth. actor: After by the fune	atlo	1 D Naturel 2 Accident	5 Pending investigation	tion M 1 7			Yes 2□No							
ĭ <u>Ş</u>	or Attend after deeth Diractor: /	tffc	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)					
	Ital or Irs after al Dir	Certification:													
	To the Hoapital or At within 24 hours after or To the Funeral Diract completaly filled in by	edical										enner es steted.			
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	T VIII		Los Signeture eno	AAA AAA	TER.	11.		29c. Licens			29d. Deta signe				
	d	2	JU	my	J. OUM	M			51118		July 13, 199				
	8		Te if	201	completed cause of de	eth (Item 23e)	(Type, Pi	rint)	Talana II	1 malana 11		7.11	morz, MD 212		
	Sta	*0	31. Dete filed (Mon		32 Registrar				Jonns F	labking H	ospital,	Dathi	MOY E, MID 42		
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Registrar

State of Maryland / Department of Health and Mental Hygiene Q 7

				Otate of Wil	aryland / t		icate of	Death		Reg. No.	21	1391
	Dhysiai		1. Dacedant's Name (First, Middla, L.	ast)					2. Data of De		Yaar 3	3. Tima of Death
	Physici /Medi		John	Norris	Sr				July 1	2 199		:30 PM
	Examir	ner	4a. Facility Nama (If not institution, gi					4b. City, Town, or				
			Meridian Nursi				Under 1 Year	Annapol If Under 24 Hrs		Anne		
	Funeral Director			453M OFF	a (In yrs. last bir 80		onths Days			1916	9. Birthplace Country) Brook	(Stata or Foraign
	dand wo		10a. State 10b. County		10c. City, Tow	n or Locatio	n				10d.	Insida City Limits
	Mary Fied	to	MD Anne An	rundel	Crown	svil	le					1 ☐ Yes 2 ☐ No
	r 282	rec	10e. Street and Number			10	0f. Zip Coda			10g. Citizan of W	hat Country?	-
	th wit	aiD	501 Palisades				21032			U.S.A.		
	- dea	Funeral Director	11. Maritel Status	12. Was Dacedent   Armed Forcas?	Evar in U,S.	13. Was	Decedant of h	Hispanic Origin? (S en, Maxicen, Puar	Specify Yas or No-		- Amarican I	
21215-0020	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or Items 23e or 28e-f show event, the Medical Examiner must be notified at	by	1 ☐ Navar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yas 2 ☐ Yas, Giva Yaar or Datas:	No		Yas 2 No			Specify:		
5-0	72 h netu	Completed	15. Decedant's E (Spacify only highast gr	ducetion ade completed)	16a.	Decedent's	s Usual Occup of work dona	pation during most of wo d)	rking	16b. Kind of Bus	sinass/Indust	гу
121	vithin ne. han "	mpi	Elementary/Secondary (0-12)	College (1-4or 5	1+)							
	be filled v stal Hygie d other t event,		12 17. Fether's Nama (First, Middle, Las	3	Co	ntra	ctor .	- Diver	ma (First, Middla,			truction
Maryland	should be filed withind Mental Hygiene. marked other than matic event, the M	o Be	Clifford Norri	•					The second	maidan Damame	·	
ary.	2 should and Men is marke eumatic	2	19a. Informant's Name/Ralationship		19b	o. Mailing Ac	dress (Street	Laura I		er. City or Town. S	Stata. Zip Co	da)
	C/ 10 00		John H. Norris		on 5	01 P	alisa	des, Cr	ownsvil	le. MD	2103	2
Je,	of Health item 27 l		20a. Mathod of Disposition		20h Pleca o	f Disposition			Data	20c. Location - 0		
Baltimore,	permit. Pages 1 end Decartment of Health Important: If item 27 any Injury or other th		1 Burial 2 Cramation 3 4 Donation 5 Other (Space	fy)		len P	ark		7/15/97			
Ba	Depa impo		Datt H	all				y Funer ely Ave			s, MD	21401
			23a. Pert1. Entar tha disaase or con shock, or heart failura. Lui only	plications that caused one ceuse on each lin	tha daath. Do i	not antar the	a moda of dyi	ng, such as cerdia	c or respiratory ar	rest,	Inte	proximata ervel Between
	Physician /Medical		Immadieta Causa (Final								On	sat and Death
1	Examiner		diseasa or condition rasulting in death)	e. CONG				TFAI	LURE		Y	EARS
		Je.			Dua to (or as a					_		-6.1
	betra b	Examiner	Convention list conditions	b	Dua to (or as a	CONSEQUENCE	- (C) 12	RYD	ISEAS	2	7	TEN
0	an an		Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disease or injury									YEARS
68760,	ficate be execute g physician and ss the burial-trans	edicai	that initiated avents rasulting in daath) Last	C	Dua to (or as a	consaquanc	e of):				1	
	25 Ch m			d							į į	1 58
Box	death cert e attendin ed for use	Physician/M		d.							1	
	8 4 8	ysic	Part II. Other algnificent conditions	contributing to death bu	ut not resulting Ir	n tha under	lying cause gi	ven in Part I.	23b. Dld 1	tobecco usa con	tribute to the	e cause of death?
P.O.	2 28		CHRONIC AT	RIACE	BRIL	LAT	ON		1 🗆 '	Yes 2 No	3 Probabl	ly 4 Unknown
of Vital Records,	raquires een signe hould be	d by							24a. Was	an autopsy	24b. Wara	autopsy findings ble prior to
8	- D 10	lete	METASTAT	ic pro	STAT	-6	CAN	cer	parfo	rmad?	availat comple of deat	etion of cause
Be	The law ate has b page 2 s	Completed							101	ras 2 1 No		as 2□No
tal		BeC	25. Was casa refarred to medicel					26. Place of De	ath (Check only o	20 243	- 1011	13 2 110
>		To B	examiner? 1 ☐ Yas 2 ☐ No	Hospital: 1 ☐ Inpatia	nt 2 ER/Ou	utpatient 3	DOA Oth		Homa 5□ Rasio		r (Specify)	
			27. Marman Death 1 Death 5 □ Pending	28a. Date of Injur (Month, Day	y Yaar) 28b.	Time of	28c. Inju Wo			now injury occurre		
Sio	Attending ar death. ector: Aha by the fund	atic	2 Accident invastigation	n		N	<b>И</b> 1□	Yas 2□No				
Division	or Attendantstee Streetor:	Certification:	3 Suicide 6 Could not t 4 Homicida datarmined		ury - At homa, fa c. <i>(Spacify)</i>	arm, straet, f	factory, offica		28f. Location (S City or Tov	Straat and Numbe vn, State)	er or Rural Ro	outa Numbar,
0	Marie and Marie		00 0 17									
B	the Hos the Fun tpletely	Medical	(Check only 2 ☐ Madicel Exa	nyalclan: To tha bast of minar: On tha basis of and mannar sta	axamination an		gation, in my o	opinion, death occ	urrad at tha tima,	data and place, a	nd dua to the	e ceusa(s)
-	0 100	2	29b. Signatura and title of ceptifiar			,	29c. Licans			29d. Data signad		
			Ma	- MS	MPT	-	P	3832	-8	JULY	14,	1997
			30. Name and address of person who									10.00
			MANY R 31. Data filad (Month, Day, Year)	CL HV G	E 18	OAD	MINI	92 coc	HNANE	PR	ANN	11410015
	Sta Registr		JUL 1 5 1997	Juli B	ar's Signatura Widson-R	andelle					MO	21401



FOR STATE REGISTRAR

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DIVISION OF VITAL HECORDS, P.O. BOX 13146,	TAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	as more printed. After the considerate have been stoned by the other others also also and commission
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	1. OECEOENT'S NAME (First, Mi	OOM, LIIST)	- 4		1				2. DATE OF C			1 3	TIME OF OEATH
	Katheri	1/100	M.	Ma	rul				MONTH	DAY /2		YEAR	1035
	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs.	. last birthday)	IF UNDER 1 YEA	AR IF UNDER	24 HRS.	7. DATE OF B	IRTH		. BIRTHPLA	ICE (State or Foreig
	213-20-667	2	1 M 2 F	90	YRS.	MONTHS DAY	S HOURS	MIN.	(Month, Den) Dec. 2			Country)	timore
	9a. FACILITY NAME (if not institu	ution, give atn				9b. CITY, TOW	VN OR LOCATIO					Y OF DEAT	
OR	Frederick		la Nurs	sing H	ome	Balti	more				Bal:	timo	re
DIRECTOR	RESIDENCE OF DECER	DENT b. COUNTY			10c. CITY	, TOWN OR LO	CATION					100	d. INSIDE CITY
E I	Marylland 1	Balti	imore		Cat	onsvi	11e					1 [	LIMITS?
AL	10e. STREET AND NUMBER						10f. ZIP CODE				10g. CITIZE	EN OF WHA	COUNTRY?
FUNERAL	1795 Westcl	heste	er Aver	nue			2122	8			Unit	ted :	States
5	11. MARITAL STATUS  1 Never Married 2 Ma	rried		T YES 2	ARMED	If yes	DECENDENT Of apacify Cuber	, Maxican,			or No 1	4. RACE — Black, W	American Indian hita, atc.
BY	3 Wildowed 4 Olvorce		IF YES, GIVE Y	WAR OR DATES	_	101	YES 2 NO	Specify:				Specify:	white
8	15. DECEDI (Specify only his	ENT'S EDUC		16a.	DECEDENT'S	USUAL OCCUP	ATION most of working	2	16b. KINI	D OF BUSI	NESS/INOUS		
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COMPL	J. O	(- / A)		n	omema	ker	1			n ho			
	Edward Schr		en						e (First, Middle se Bo		umame)		
BE	19a. INFORMANT'S NAME (Type	_			19b. MAILINO	ADDRESS (Stre					State, Zip C	Code)	21220
5	Joyce Davis, niece 1795 Westchester Avenue Catonsvil:												21228 e, MD
	20e. METHOD OF DISPOSITION  20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place)  20c. LOCATION — City or To other place)												
	4 Donation 8 Other (Sp	pecify)		Lou	don P	_	emete	_		Ba1t	imor	re,Ma	arylan
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month **Physician** Dey Galina Polishchuk July 10 0600 AM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Randalls town Northwest Hospital Center 7. Aga (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) SEPT 25,1929 Baltmore 5. Sociel Sacurity Number 6 Sex Birthpleca (State or Foreign Country)
 RUSSIA **Funeral** 1 M 200 F 218-41-1649 Director Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Itama 23a or 28a-f ehow the Medical Examiner must be notified at MD BALTIMORE OWINGS MILLS 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 917 JOSHUA TREE CT. 21117 RUSSIA 12. Was Decadent Evar in U,S. Armad Forces? 1 Yas 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Naver Married 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: à Specify: 3 Widowed 4 Divorcad WHITE Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pagas 1 and 2 should be filed w Department of Haalth and Mantal Hygiene Important: If Nam 27 is marked other that any injury or other traumatic according HOUSEKKEEPER HOTEL 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumama) VASILY **GUSLAVSKY** UNKNOWN MOTYA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 917 JOSHUA TREE CT. MRS. JANNA OSTROVSKY (DAUG.) OWINGS MILLS, MD 21117 20b. Plece of Disposition (Name of cemetery, crematory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 X Burlal 2 Cramation 3 Removal from Stata 7/11/97 DRUID RIDGE PIKESVILLE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23a. Part1. Enter the disassa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer prince. List only one ceuse on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physiclan and the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, laading to Immediata cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last Box 68760. Urosep815 Physician/Medical P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown auto rend failure Records, þ Completed 24a. Was en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? 1 Yas 2 No 1 Yes 2 No cartificeta Division of Vital al or Attanding Physician: The saftar deeth.

In Diractor: Aftar this cartificete of in by the funeral director, pa 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturel 5 Pending 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide neral C 29a. Certifier 1/2 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the ceuse(s) end manner as steted. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and manner stated. FA BOL 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) July 10, 1997 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 540 4 OH Court Rd-Randallstown 21133 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death JULY 11 1997 ear PATT 12:12pm 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth LORIEN NURSING HOME COLUMBIA HOWARD If Under 1 Year Months Deys If Under 24 Hrs. Hours Min. 8. Date of Birth NOV. Day 3 (ear) 1908 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Months 1**∏**M 2□ F 88 NEW YORK Yrs. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No HOWARD COLUMBIA 10f. Zip Code 10g. Citizen of Whet Country? 6334 CEDAR LANE 21044 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo If Yes, Give Yeer or Detes: 1 ☐ Yes 2 XNo 3 Widowed 4 □ Divorced Specify: WHITE 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PHYSICIAN MEDICINE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) PATT BESSIE KATZ 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) DR. PHILIP PATT (son) 11412 elfstone way COLUMBIA, MD 21044 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) STAR OF DAVID 7/13/97 N. LAUDERDALE, FL 21. Signature of Funeral Service Lips see 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. cations that caused the death. Do not enter the mode of Synt, Such as cardiac RD espirator ares VILLE, MD Due to (or es e consequence of) Due to (or as a consequence of)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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**Funeral** 

Director

ortant: if item 27 is marked other than "natural", or items 23a or 28a-1 show Injury or other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any Injury or other traumatic event

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

the Maryland

death with

DR. JESSE

5. Social Security Number

MARYLAND

10e. Street end Number

ARTHUR

20a. Method of Disposition

Immediate Ceuse (Final disease or condition resulting in deeth)

109-36-5942

Usual Residence of Decedent

physician and s the buriel-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting In death) Last Physician/Medical

by

Completed

Be

Certification:

edical

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was en eutopsy performed?

24b. Were eutopsy findings eveileble prior to completion of cause of deeth?

1 ☐ Yes 2 No

1 ☐ Yes 2 ☐ No

26. Plece of Death (Check only one)

25. Was case referred to medical exeminer? 1 Yes 2 No

5 Pending investigation

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year)

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a, Certifier

27. Manner of Death

1 Natural 2 Accident

3 Suicide

4 ☐ Homicide

1 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and menner es steted.

2 Medicef Exeminer: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dey, Yeer)

6 Could not be determined

eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Two knoll North DR. Columbia MD 21045 1 apou Medica 31. Date filed (Month, Day, Year) 1 5 1997

State Registrar

• Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific

24 hours

within 2 To the

funeral

filled in by the

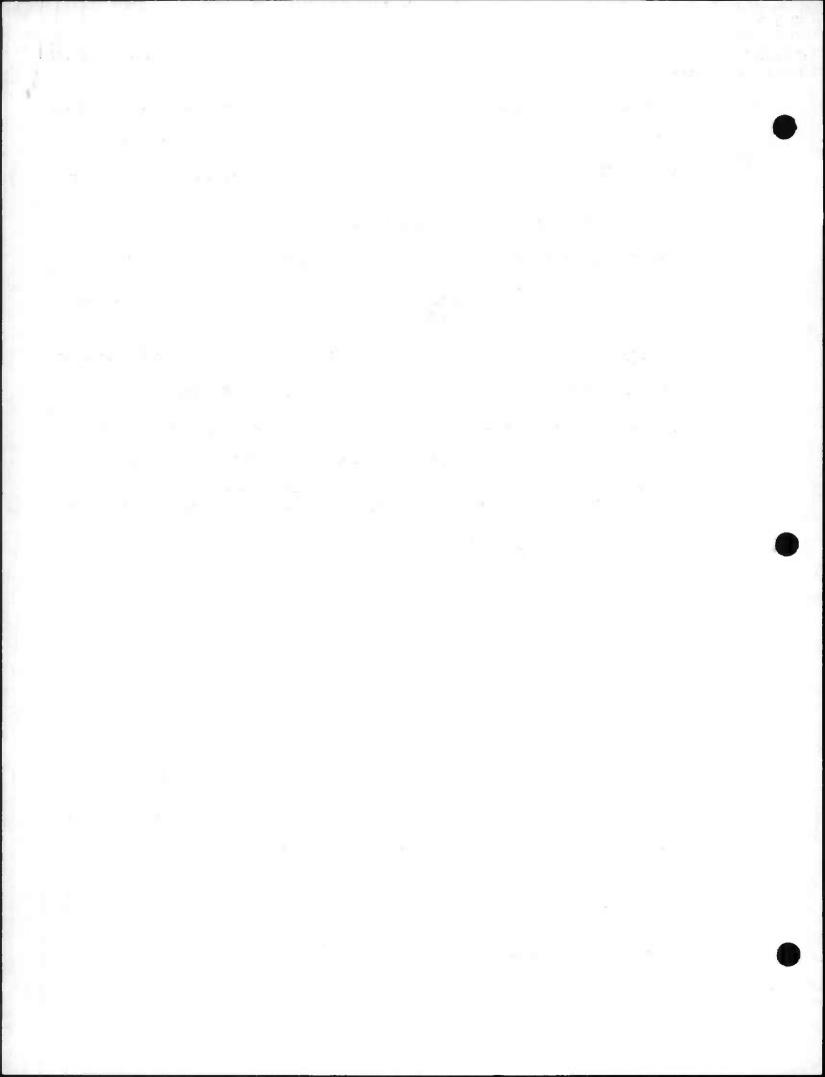
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State of Maryland / Department of Health and Mental Hygie

Ste

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No							

even	Keith	Pa	rker		Ce	rtificate c	f Death	7	R	leg. No.		
			1. Decedent's Name (First, Middle, L	ast)					2. Dafe of Dee	th		3. Time of Deeth
	Physici		Steven Keith	Parker					July C	)9, 199°	Year 7	4:00 P
	/Medic Examin		4a. Fecility Neme (If not institution, g	ive street end number)			4b. City, To	own, or Loc	cation of Deeth	4c. County		1.00 2
	LAGITIT		RT. 24				FOR	EST H	ILL	HARI	FORD	
	Funeral		Social Security Number 6.	Sex 7. Age (In y	rs. last birthday)	If Under 1 Ye	ar If Unde		8. Date of Birth (Month, Dey		9. Birthp	place (Stete or Foreign
-	Director		167-44-0725	<sup>1</sup> √x <sup>M</sup> <sup>2□</sup> F 37	Yrs.	Months De	ys Hours	Min.	10/10/		Coun	PA
	D		Usuel Residence of Decedent						10/10/	22		FA
	how		10e. State 10b. County	10c.	City, Town or Lo	ecation					11	0d. Inside City Limits
	e Ma	cto	PA Chest	er	Coates	ville						1□Yes 2□No
	4 25 th	Director	10e. Street end Number		101	10f. Zip Cod	ө		1	0g. Citizen of	Whet Coun	itry?
	th w		100 Birchview I	rive			1932	0		U.S.	Α.	
	ep .	Funeral	11. Maritel Status	12. Wes Decedent Ever in Armed Forces?	n U,S. 13.	Was Decedent of If Yes, specify C	of Hispenic Or	rigin? (Spe	clfy Yes or No-	14. Rac	e - Americ	
0	or it		Never Married 2 Married	1 ▼ Yes 2 No		1⊊Yes 2□ N			110411, 010.7	Specify		
00	aral'.	d by	3 Widowed 4 Divorced	Year or Dates: 9/	/-	41				Specif	wh:	ite
Maryland 21215-0020	72 h	Completed	15. Decedent's (Specify only highest g	Education	978 6e. Decer (Give life.	dent's Usual Ock	cupetion ne during mos	st of workin	ng	16b. Kind of B	usiness/Inc	Justry
12	Pa .	Пp	Elementary/Secondary (0-12)	Coltege (1-4or 5+)	life.	DO NOT use ret	rired)					
2	lygie lygie nt.		12TH		La	awn Care	}					oloyed
n i	d oth	Be	17. Fether's Neme (First, Middle, Las	51)			18. Moth	er's Name	(First, Middle, I	Maiden Sumen	10)	
<u> </u>	Mar Marke marke	To	Roy H. Parker				Aı	nnett	e M. He	SS		
a	2 sh end Is m		19a. Informent's Neme/Relationship	(Type, Print)	19b. Mailir	ng Address (Stre	eet end Numb	er or Rure	Route Number	r, City or Town,	Stete, Zip	Code)
0	and lealth m 27 her t		Susan Parker / St	ep-mother	701	W. Firs	t Ave.	; Par	kesburg	, PA	19460	
oro	of F		20a. Method of Disposition      © Burial 2 □ Cremetion 3	□ Removal from State	o. Plece of Dispo cemetery, crer	netory or other p	plece)	į	Date	20c. Location -	City or To	wn, State
altimore,	men ant:		4 ☐ Donetion 5 ☐ Other (Spec	ify) M	lorris C	emetery		7	/14/97	Phoenix	<pre><ville< pre=""></ville<></pre>	e, PA
a	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heath and Mantal Hygiene. Department of Heath and Mantal Hygiene. Important: I flew marked other than "natural", or items 28e or 28s-f show any injury or other traumatic event, "to Medical Examiner must be notified at once.		21. Signeture of Funeral Service Lice	ensee	22	2. Name end Ad						
Ω	20 = 20		Christina	1 Kopen	K	Johnson	ach Da	D	1 m	011000	MD 2	1206
-			23a. Pert1. Enter the disease, or conshock, or heart faiture. List only	mplications that caused the	ath. Do not ent	er the mode of	dying, such es	cardiac or	r respiratory err	est,	IND Z	Approximate Intervel Between
F	hysician		orious, or rough landro. List of	y 0110 04430 011 0001 1110.							1	Onset end Deeth
	/Medical		Immediate Ceuse (Final disease or condition	Multipe	Laure						1	
ı '	Examiner		resulting in deeth)	e. Multiple	o (or es e consec	quence of):						
	n &	ner				1901.1106					1	
	artificata be executed ing physician end a es the bunel-transit	Examiner	Sequentiatly list conditions.	Due to	o (or es e consec	quence of):						
ó	an e	Ä	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury								į	
68760,	nta be nysici	edical	that initiated events resulting In deeth) Last	cDue fo	(or es e conseq	uence of):						
39	dg ph es ti	Med	resulting in deetin) Last								1	
XO	eath ce attendii I for usa			d							-	
.0	lew requires thet tha death ce as been signed by the attend a 2 should be detached for us.	Physiclan/	Pert II. Other significent conditions	contributing to death but not	resulting In the u	nderlying cause	given in Pert	I.	23b. Dld to	obacco use co	ntribute to	the cause of deeth?
Records, P.O	by the	F)							1 🗆 Y	es 2 No	3 Prot	bably 42 Unknown
Ś	gned be de	by										
ord	been si should	g							24e. Was e	n eutopsy	24b. We	ere eutopsy findings eilable prior to
သို	sw re	Completed							,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		COL	mpletion of cause deeth?
Œ	e de	E							1 🗆 Y	es 2 No	10	Yes 2X No
E /		BeC	25. Was case referred to medical				26. Plec	e of Death	(Check only or			
Division of Vital	Rich (displaying)	ToB	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2	□ ER/Outpetier	t 3□ DOA	Othor		ne 5□Reside		er /Specifi	v) MUZ
0	E ED		27. Manner of Deeth	28e. Date of Injury	28b. Time of				8d. Describe h			ALIVA
0	th.:	읉	1 ☐ Natural 5 ☐ Pending 2 🔀 Accident investigati	on 7/0/07	3 14		Vork? ☐ Yes 2.	No .	motorcy	che coli	11510N	
<u>  </u>	or Attanding after daeth. Director: Aft d in by the fur	fice	3 Suicide 6 □ Could not	A 289. Place of Injury - A	t home, farm, str	eet, factory, office	ce		Rf Location /S	treat and Numl	nor or Puro	al Route Number,
	after Direction by	Certification:	4 ☐ Homicide	building, etc. (Spe	scity) Street	of				n, Stete) R.+		
	spira hours neral y fille		29a. Certifier 1☐ CertifyIng P	hysician: To the best of my	nowledge, deeth	occurred et the	time, dete er	nd place, a	nd due to the c	euse(s) end ma	anner es st	teted.
	Fu Petel	edlcai	(Check only one) 2. Medical Exa	miner: On the besis of exam end manner stated.	ination end/or in	vestigation, in m	y opinion, dea	ath occurre	d et the time, d	ate end plece,	end due to	the ceuse(s)
	lo the Hospital of Attanswithin 24 hours after daet To the Funeral Director: completely filled in by the	Me	29b. Signature end title of certifier	- 4		29c. Lice	ense number		2	9d. Date signe	d (Month, I	Dey, Year)
			by A	Ch. f		(	CME			July 1	0.10	997
	VXI		30. Name end eddress of person who	completed cause of death /	tem 23a) (Tyne					CULY I	.0, 13	,,,
	7		Dennis J. Chi		111 Peni	•	. Ral+	imor	a. Mass.	land of	201	
	Sta	te	31. Date filed (Month, Day, Year)	al 20 Degistraria Ci		rorree	_/_Dall	THOL	e/ mary	Taila 21	ZUL	
	Registr		JUL 1 5 1997	Julia Mavidson	Bindell							



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. t. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1:55 Am 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (Str t & M 2 | F 7200 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number. 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR TIMORE RESIDENCE OF DECEDENT toe. STATE tob. COUNTY IOC. CITY, TOWN OR LOCATION tod. INSIDE CITY 1 FES 2 NO permit. FUNERAL 10e STREET AND NUMBER 101. ZIP CODE tog, CITIZEN OF WHAT COUNTRY? 1 page 5 should be detached for use as the burial-transit 13. WAS OECENOENT OF HISPANIC ORIGIN? (Specify Yea or No-If wes. specify Cuban, Maxican, Puerto Rican, etc.) after death. Page 6 may be retained by the hospital or attending physician tt. MARITAL STATUS WAS DECEDENT EVERTH U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES BALTIMORE, MARYLAND 21215-0020 t4. RACE — American Indian, Black, White, etc. It yes, specify Cubs 2 Warried t Never Married Specify: BY 3 Widowed 4 Divorced DREAN COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY /Secondary (0-12) College (t-4 or 5+) 迈瓦 DORER ts. MOTHER'S NAME (First notified at BE 0 pe 200. PLACE AND DATE OF DISPOSITION must 3 DB urial 2 Cremittion funeral director, m 5 0 examiner illed in by the medical 23. PART Extended the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or Approximate ock, or heart fallure. List only pr intervai Between ceuse on each line. 6 IMMEDIATE CAUSE (Final Onset and Death cremation, traumatic event, the hermana disease or condition wool resulting in death) complete TO (OR AS A CONSEQUENCE OF): DIVISION OF VITAL RECORDS, P.O. BOX 68760 woters bunial, /week CERTIFICATION and Sequentially list conditions, prior to 1 if eny, leeding to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior to fales evelow os culas other t CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST 0 PART II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL Health and PERFORMED WAII ARLE PRIOR TO any COMPLETION OF CAUSE OF DEATH? t TYES 2 Shows T YES 2 NO has been s Dept. of H PHYSICIAN: OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h Item EXAMINER? HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA I YES 2 OTHER: Nursing Home 5 - Residence 8 - Other (Specify) 0 the 27. MANNER OF CEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED marked, t Natural 2 Accident 5 Pending Investigation t YES 2 NO DIRECTOR: After the hours after death v BY 28e. PLACE OF INJURY — At home, farm, street, factory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 8 S Could not be determined COMPLETED 28 4 Homicide Hem t CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) TO THE HOSPITAL
TO THE FUNERAL (
be filed within 72 h
IMPORTANT: If II (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day. BE tendry Doctor D 216 7-10-0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MUT CTRIAL-M-D 8109 IT CHIB LAN AFFORDANTS SIGNATURES A SECOND

DHMH-16 Rev 1/89

State of Maryland / Department of Health and Mental Hygiene

21403

					Ce	rtificate o	f Death	•	Reg. No.	7 1	41400
	Dhusia		1. Decedent's Name (First, Middla, Las	st)				2. Date of De		Voor	3. Time of Death
	Physic /Medi		Ann McComas P	hillips				JULY	12,	1997	1915
	Exami		4e. Facility Neme (If not institution, give	streat and numbar)			4b. City, Town, or L	ocation of Deat	h 4c. County	of Deeth	
			St. Agnes Hospit				Baltimo		N/Z	A	
1	Funeral Director	ŀ	5. Social Security Number 6. Security Number 11	T. Age (In)	yrs. last birthday) Yrs.	If Under 1 Year Months Day		(Month, De		9. Birthp Coun	place (Stata or Foreign ntry)
			Usual Residence of Decadent	X 33				08/20	/1961		MD
	yland		10e. State 10b. County	10c.	City, Town or Lo	ocation				1	Od. Inside City Limits
	Mar Mar	Ş	Md Baltim	ore	Cato	nsville					1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	Whet Coun	ntry?
	23a	2	15 Arkla Court			21228			USA		
	tems Nat.m	Funeral	11. Maritel Status	12. Was Decedent Ever i Armed Forces?	n U,S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Rec Bla	ce - Americ	
20	72 hours after death with the Maryland natural; or items 23a or 28s-f show dical Examiner must be notified at	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Dates:		1□ Yes 2□N	o Specify:		Specify	y: ,	
21215-0020	"natural", or	Pa	15. Decedent's Ed		16a, Dece	dent's Usual Occ	upation		16b. Kind of B		ite
215	within 72 ana. than "m	Completed	(Specify only highast grad	da complated) College (1-4or 5+)	(Giva	kind of work don DO NOT usa ratii	a dunna most of work	king			3401.7
	d with	ĕ	12	Conege (19401 34)	Home	maker			Own	Home	
nd	be filed tal Hygie d other event, II	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	, Ma <i>idan Sum</i> an	na)	
<u>y</u>	2 should be filed withir and Mental Hygiana. Is marked other than aumatic event, the M	10	Robert Mellendick				Carolyn	McComas	5		
Maryland	12 sh h and h and ls m		19a. Informant's Name/Relationship (7) Terry Phillips/Hus				et and Number or Rui		-		Coda)
	s 1 and 2 should be filed within 72 hc Haaith and Mental Hygiana. Item 27 is marked other than "natur other traumatic event, Its Medical		20a. Method of Disposition		b. Plece of Dispo		rt, Catons	Date Date	Md. 212		num Ctata
altimore,			1 Burial 2 □ Cremation 3 □	Removal from State	cematary, cra	matory or other p					
Ħ	permit. Pa Departman Important: any Injury once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signeture of Funeral Service Licen.			Forest  Name and Add		/16	Owings	Mills	s, Md
Ba	permit. Page Department of Important: If any Injury or once.				Ct	corlina	Achton D.	neral Ho	ome, Inc	)	
			23a. Part1. Enter the disease, or comp shock, or heart feilure. List only of	lications that caused the d	leath Do not en	36 Edmon	dson Avenu	e, Balt	o, Md.	21228	Approximate
	Physician		shock, or heart feilure. List only of	ne cause on each line.			, 9,	o. reopiiatory o			Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition	ASYG	Ole					K	Lew priant
	Examiner		resulting in death)	8.	o (or as a conse	quence of):				1	
	ים מ	ine	_	JAA8	15						days
	be executed ician and burist-transit	Examiner	Sequentially list conditions,	Due to	o (or as a consec		. 0				lew driants days any drouth
60,	cate be an physician a the buria		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c. Three			Ulcer			40	sale growth
68760,	rificate be exe ng physician a s as the burisi-	Medical	that initiated events resulting in death) Last	Due to	o (or es e consec	juenca of):					
Box				d							
	s death ce the attend hed for use	Physician/	Part II. Other eignificant conditions co	ntributing to death but not	resulting in the u	nderlying cause o	riven in Part I	23b. Dld	tobacco use co	ntribute to	the cause of death?
P.0	£ 45	hys			•	,	,		Yes 200 No		bably 4 Unknow
	2 5 8	by 6	3000	sis Kligia							
Records,	r requires been sign should be	ted	Parap	Kligia_				24a. Was	an autopsy ormed?	eve	ere autopsy findings eileble prior to
9	20 E	Completed	<i></i>	0		*				of o	mpletion of cause death?
H	를 물질	Co						1 🗆	Yes 2000	10	Yes 25 No
Vital	telan cartifu nactor	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Deat	th (Check only	ona)		
to	Physician: this carific ral director,	: To	1 ☐ Yes 2 ☐ No  27. Menner of Death	1 L Inpatient 2	28b. Time o	II SLI DOA			dence 6 Oth		(V)
Division of	Affect	tlon	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28e. Date of Injury (Month, Day Year	r) Injury	W	ork? ☐ Yes 2 ☐ No	200. Describe	now injury occur	100	
/isi	Attending r death. sctor: Alte by the fund	Ifica	3 Suicide 6 Could not be	286. Placa of injury - A	t home, farm, str			28f. Location (	Street and Numb	ber or Rura	Il Routa Number,
ā	of Die	Certification:	4 ☐ Homicide determined	building, etc. (Spe	ecify)			City or To	wn, State)		
1	Non in		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam)	sician: To the best of my i	knowledge, death	n occurred at the	time, date end place,	and due to the	cause(s) and ma	anner as st	teted.
17	1	<b>ledical</b>	one)	ner: On the basis of exam and manner stated.	mation end/of In			ied at the time,			
-	2 8	Σ	29b. Signature and title of certifier	1 000	-	29c Licer	nse number		29d. Date signe	d (Month, I	Day, Yaar)
	-		L'Allbaro Ku	EKA	Touling	19	0556		JULY	12,	1447
	5		30. Name and address of person who c	ompleted cause of death (	Item 23a) (Type,	Print)	Balt-	1.000	ManyRa	and O	21200
		•	31. Date filed (Month, Day, Yaar)	32. Registrer's Si	greture	902 NVC	- Dans	very 1	- wy	000	1120-1
	Sta Registr		JUL 1 5 1997	Julia Davidson-	Randa 00						
				/	Luciano						

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician ANTS** MARGARET **PUGH** Ju1y 11, 1997 /Medical 5:57 a.m. 4a. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Stella Maris Hospice Baltimore County Baltimore If Under 24 Hrs. 8. Date of Birth
Hours Min. May 15, 1958 If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (Stete or Foreign Country) Deys Months 1□ M 2□ F Yrs 39 Director 218-78-4582 Baltimore, Maryland Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location "natural", or items 23e or 28a-f show oficial Examiner must be notified at 10d. Inside City Limits Directo 1 ☐ Yes 2√ No Harford Maryland Whiteford 10e. Street and Number 10f Zip Code 10g. Citizen of Whet Country? with 4090 Prospect Road by Funeral 21160 LISA filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Maritel Stetus 14. Race - American Indian. Bleck, White, etc. 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No If Yes, Give Yeer or Dates: 21215-0020 1 ☐ Yes 2 ☐ No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 7 is marked other than "nature treumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry completed) Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) N/A Graphic Designer Pugh Design altimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Peges 1 end 2 should be f nent of Health end Mental I Raymond Milton Byrd Jeannine Louise Kling 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) nt of Health e if item 27 is or other tre Randy G. Pugh (Husband) 4090 Prospect Road Whiteford, Maryland 21160 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete XXX Burial 2 Cremetion 3 Removel from Stete permit. Pege Depertment of Important: If any injury or Gardens of Faith Cemetery July 14, 1997 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Lassahn Funeral Home, 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on each line. Inc. 7401 Belair Road Baltimore, Maryland 21236-4625 Approximete fntervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Metastatic cervical cancer Examiner 2 yr. 7 mos Due to (or es e consequence of) The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest the buriel-tren Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. physiclan Physician/Medical Due to (or as e consequence of): use es signed by the 6 Pert il. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Minknown þ Completed 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? peen certificate has 1 Tyes 2 XINO 1 ☐ Yes 2 ☐ No Physician: Be 25. Wes cese referred to medicel exeminer? 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6\( \text{XIOther (Specify)} \) HOSPICE ဥ 1 Yes 20 No 3□ DOA this Certification: 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After Attending after dee...
Director: After 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide ò Contying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted.

The contying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the ceuse(s) end manner es steted.

The contying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the ceuse(s) end manner es steted. 29e. Certifier Medical (Check only one) 29b. Signature anglet e of certification 29c. License number 29d. Date signed (Month, Day, Year) 1558 4 7-30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print)

2300 DULANEY VALLEY RD.

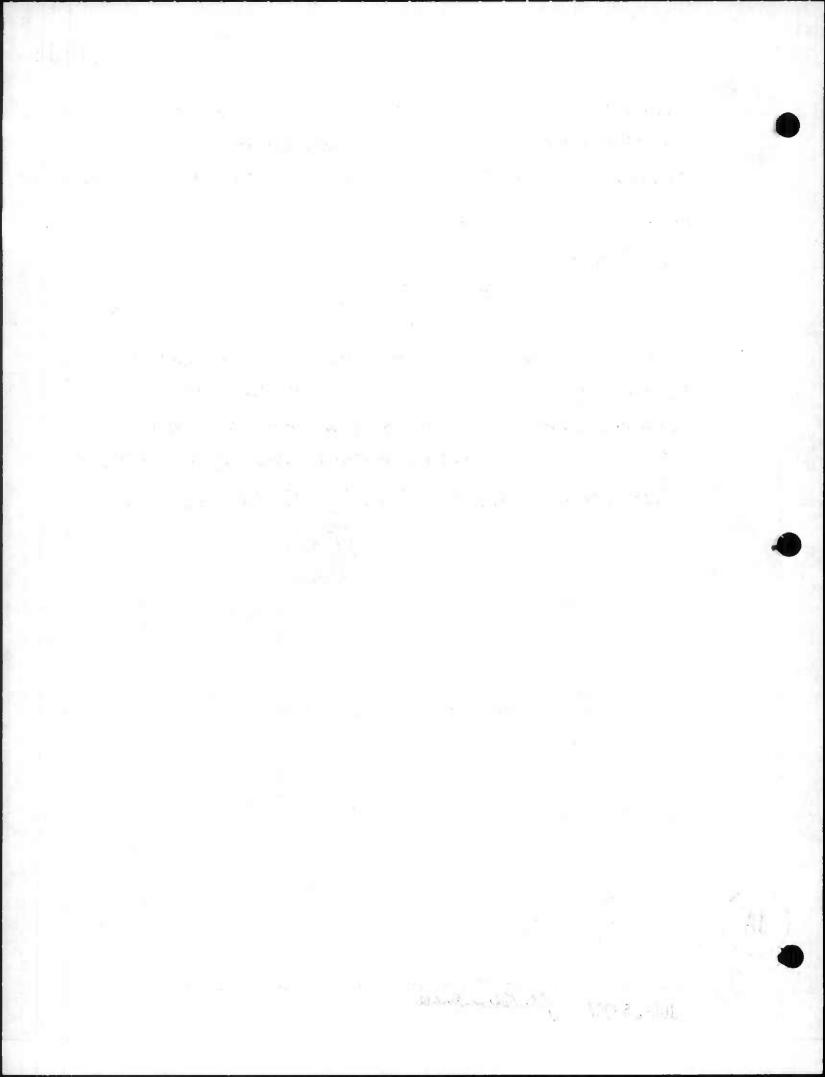
Aulia Beligarer Floridate

TIMONIUM, MD 21093

Registrar

EDDIE NAKHUDA

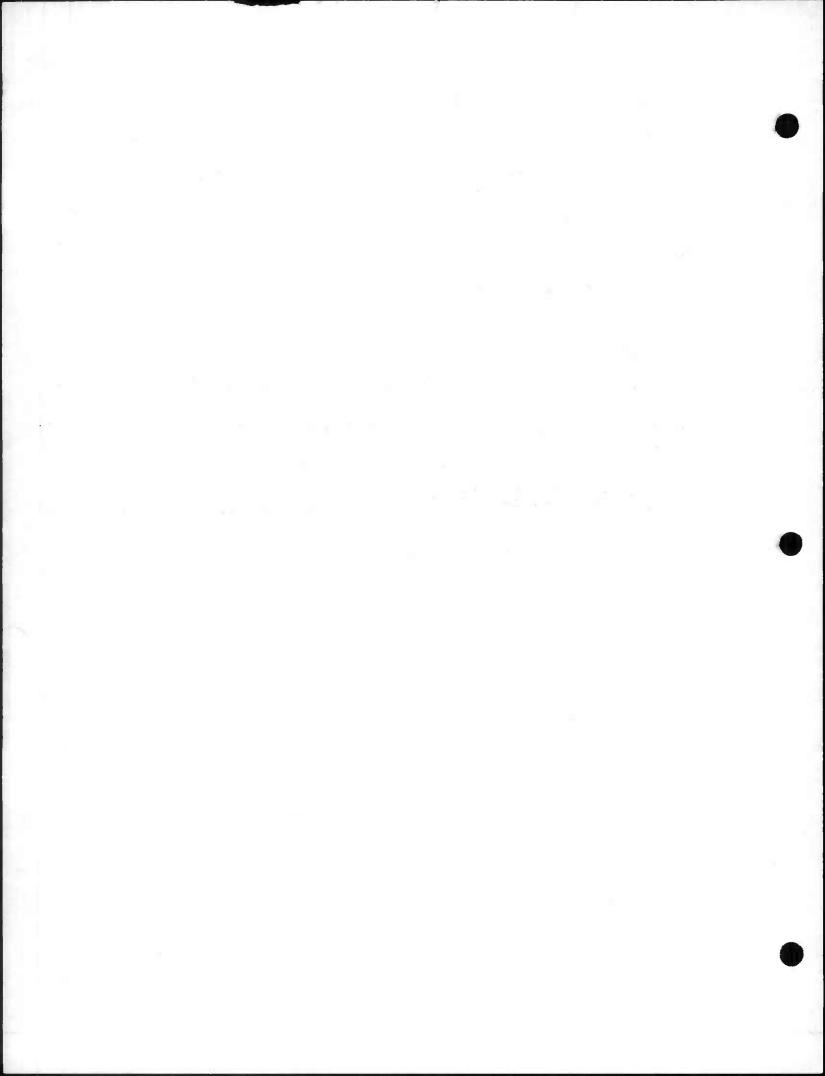
31. Date filed (Month, Day )



State of Maryland / Department of Health and Mental Hygiene

21405

					C	ertificat	e of	Death			Reg. No		•	21400
	Physici /Medi		1. Decedent's Name (First, Middle, Le TREVE R	. PLOCI	4					2. Date of De Month			ar 77	3. Time of Deeth 5:12am
	Examir		4a. Fecility Name (If not institution, giv		12005					ocation of Deal		County of I		
		F.	ALRITAGE	NURSING M		. H Llader	1 Van	N/				altin		
	Funeral Director		5. Social Security Number 6. S 177120133 1 Usual Residence of Decedent	M 2XF	yrs. lest birthde	Months	Days		Min.	8. Date of Bi (Month, Do	rth ey, Yeer)		Birthpi Coun	ace (Stete or Foreign try)
	yland		10a. Stete 10b. County	100	: City, Town or	Location					-		10	Od. Inside City Limits
	a-f st	ctor	MD N/A		Baltin	ore								1 Yes 2 No
	ith the	Dire	10e. Street end Number			10f. Zip	Code				10g. Citi	izen of Whe	t Coun	iry?
	ath w	la l	335 S. Chester				212				USA			
	lterna Dien	Funeral Director	11. Marital Status  1 ☐ Never Married 2 Married	12. Was Decedent Ever Armed Forces?	in U,S. 1	<ol><li>Wes Deced if Yes, spec</li></ol>	dent of cify Cub	Hispanic Ori pen, Mexicar	igin? (Spo n, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - A Bieck, N		
020	72 hours after death with the Maryland natural; or items 23a or 28a-f show digal Examiner must be notified at	by	3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes	2 12 No	Specify:				Specify:	Whi	to
21215-0020	72 hor	ted	15. Decedent's Ec	ducation	16e. De	cedent's Usua	al Occu	petion	t of mode		16b. Ki	ind of Busin		
121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	ive kind of war b. DO NOT us	se retire	9d)	t of work	ing	<b>a</b> 1			
	filed within Hygiene. Ither than "		17. Father's Name (First, Middle, Last)		Sal	.es		10 Moth	ar's Nome	. (Eine Afidele		othin	ng	
an	d be f antal !	9 Be	Alexander		ablons	ki		1	atr	e (First, Middle ice	, Malden	Sumame)	Su	rdock
Maryland	2 should I and Meni is marka	P_	19a. Informant's Name/Relationship (				(Stree			al Route Numb	per. City o	r Town, Sta		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 28a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		John Ploch/Husl	band	2.3	5 S	Che	astar	Sti	reat F	alt	imore	ь M	D 21231
ore	of He of He fitem		20a. Method of Disposition  1 Burial 2 □ Cremation 3 □		b. Place of Discemetery, of	position (Nan remetory or o	ne of ther ple	ece)		Date	20c. Lc	ocation - City	or To	D 21231 wn, Stete
altimore,	Pages ment of tant: If its jury or o		4 □ Donation 5 □ Other (Specify		oly Ro	sary	Cer	neter	У	7/14	Bal	timoı	ce .	MD
Bai	permit. Pages Department of Important: If it any Injury or once.		21. Signeture of Funeral Service Licen	1509	-00	22. Name en			,	There	1	77		
_	40240		1 nuthleen u	ILBUL CF	30					Funer St. E			- M	D 21231
П	Dharistan		23a. Part1. Enter the disease, or compands, or heart failure. List only	plications thet caused the one ceuse on each line.	death. Do not	enter the mod	e of dy	ing, such as	cerdiac o	or respiratory e	errest,			Approximete Intervel Between Onset end Deeth
	Physician /Medical		Immediate Ceuse (Final	CAD DI	Par	11011		0., =	201	255				
	Examiner		disease or condition resulting in death)	a. CARDII	to (or es e con	sequence of):	MA	-9	7	7				
	P 15	Iner		. KSEUDO	Myx	MAT	бИ	2	PER	TONG	51		i	
	and i-trans	Examiner	Sequentially list conditions, if eny, leeding to immediate	b. PSEUDO Due CHRONIC	to (or es e cons	sequence of):		0						
68760,	be es sician burie		cause. Enter Underlying Ceuse (Disease or Injury thet initiated events	CHRONIC	0155	TRUCT	WE	FY	112	LONARY	D	ISEAS!	5	
687	aath certificate be executed attending physician and for use as the buriel-transit	edicai	resulting in deeth) Lest	CARUNE	o (or es e cons	equence of):		0 5/						
Вох	n cert	M/UE		d. SIRUNG	MA	of o	VAI	29					_	
. 8	requires that the death ce seen signed by the attendi hould be datached for use	Physician/	Part II. Other significant conditions co				ause g	iven in Pert I		23b. Did	tobecco	use contril	bute to	the cause of deeth?
P. 0.	at the d by ti	Phy	ABBOMINAL	fist us	Δ					1 🗆	Yes 2	□ No 3[	Prob	ably 4 Unknown
	D d	l by	1113000((141)	1131401						250 000		T	45 101-	
Records,	v requir been si should	Completed								24a. Was	en eutor ormed?	osy 2	con	re eutopsy findings bilable prior to inpletion of cause
Rec	has has	dmo												deeth?
Vital	delan: The cartificate rector, pag		25. Was case referred to predical					26 Pleas	of Doot	1 Chark anh		No	1 _	Yes 2 No
	S 0 5	To Be	exeminer? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ER/Outpet	ient 3 DO	A Ot	her:		n <i>(Check only</i> me 5 ☐ Resi		6 □Other (	Specify	)
Division of	ng Ph tter th ineral		27. Manner of Death 1 □ Maturel 5 □ Pending	28a. Dete of Injury (Month, Dey Yea	z) 28b. Time		8c. Inju			28d. Describe			, ,	
Sio	eath. tor: Al the fu	catle	2 Accident investigation 3 Suicide 6 Could not be	1		M		Yes 2						
Σ	or Attending Pisater death.    Director: After tight in by the funera	Certification:	4 ☐ Homicide determined	28e. Place of Injury - a building, etc. (Sp	At home, farm, ecify)	street, factory	, office			28f. Location ( City or To			r Rurei	Route Number,
/	d bo	-	29a. Certifier to Certifying Phy	yelcien: To the best of my	knowledge de	ath occurred	et the ti	ime date an	d place	and due to the	Causa(s)	and manns	ar se et	eted
1	De Fur	edicai		niner: On the basis of exar end manner stated.	nination end/or	Investigation,	in my	opinion, dea	th occurr	ed at the time,	date and	place, end	due to	the cause(s)
1	To the	ž	29b. Signature and title of certifier	_		290	. Licen	se number			29d. Dat	te signed (A	fonth, L	Dey, Year)
			Springer	Wjulke			19	718	8		7	112/	37	
	21		30. Name and address of person who o	completed cause of deeth			00		N.	eunder				
			31. Date filed (Month, Day, Year)	ille I	Men	ueli	1 L	Que	1)1	lunder	lu i	MD	Al.	222
	Sta Registr	_	JUL 1 5 1997	Juna Davids	n-Handel	2								



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

**Physician** /Medical Examiner

1. Decedent's Name (First, Middle, Last)

2. Date of Death

3. Time of Deeth

10d. Inside City Limits

1 ☐ Yes 2 No

21207

Approximete Intervel Between Onset end Death

12;17AM

**Funeral** 

 Birthplace (State or Foreign Country) Maryland

**Black** 

Director

the Marylend name to a series of a series o Director Funeral þ

Completed

Be

Pages 1 and 2 should be filed within 72 hours efter deeth with ment of Health and Mentel Hygiene.
ant: If item 27 is marked other than "natural", or items 23s or ury or other traumatic event, the Medical Examinas maint be 1 Depertment if important: if any injury or

21215-0020

Baltimore, Maryland

P.O. Box 68760

of Vital Records,

Division

**Physician** /Medical **Examiner** 

Examiner 8 Physician/Medical 2 þ Completed D&D6 2 certificate Be Certification: To ä Affer Attending after deat Director: Bu hours

Day TYONDA ROLAND JULY 1997 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 1200BLK. CHURCH STREET BALTIMORE N/A 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Days Hours 1□M 2√2F 213-96-3820 Yrs. 16 8/11/1980 Usuel Residence of Decedent 10a, State 10b. County 10c. City. Town or Location MD BALTIMORE DUNDALK 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2031 PAULETTE ROAD, #203 21222 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes ঽ No Specify: Specify: 3 Widowed 4 Divorced Decedent's Usual Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 9th 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Mark Roland Rochelle Baker 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Karen Baker 1641 Aisquith Street, Baltimore, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State h Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) ZION CEMETERY 7/17 BALTIMORE, MARYLAND 21. Signature of Funerel Service Licenses 22. Name end Address of Fecility LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVE., BALTO. & SON FUNERAL HOME, P.A. the disease, of complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, eert fallure. Listonly one ceuse on eeer line. Immediate Cause (Finel disease or condition resulting in death) Due to (or es e consequence of)

Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest

Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes en eutopsy performed?

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical XXYes 2 No

27. Manner of Death

1 Naturel

2 Accident

4 Homicide

3 Suicide

Hospital: 1 ☐ Inpatient 28a. Dete of Injury (Month, Day Yeer) Investigetion

28b. Time of Injury 1201

Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence & Other (Specify) ROADWAY 2 ER/Outpatient 3 DOA 28c. Injury et Work? 1☐ Yes 2/1 No

28d. Describe how injury occurred

assence in motorcycle accord 28f. Location (Street and Number or Rural Route Number City or Town, Stete) 1200 BIK.

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

\*\*Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. wick o 29b. Signature and title of certifier

5 Pending

6 Could not be determined

29c. License number O.C.M.E 29d. Date signed (Month, Day, Year) JULY 11, 1997

who completed cause of death (Item 23e) (Type, Print) nd address of person

Laron Locke M.D.

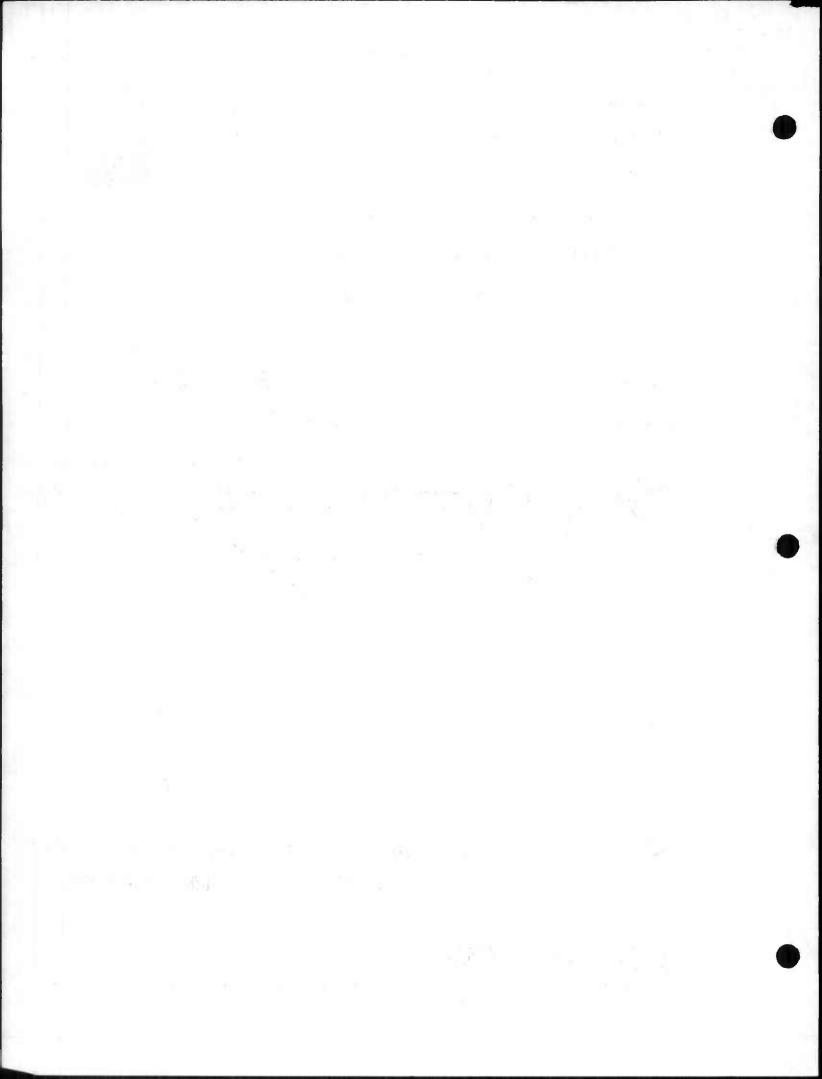
111 Penn Street, Baltimore, Maryland 21201

26. Plece of Death (Check only one)

fish out of the same of the sa

Medical

State Registrar



State of Maryland / Department of Health and Mental Hygiene

97 2140

						Ce	rtificate	e oi	Death		R	leg. No.	21	414	UI
	Discorte		1. Decedent's Neme (First, Middle	Last)							2. Date of Deel	th		3. Time of I	
	Physic /Medi		Genevieve Kath	erine Rus	ssell R	oot					July	Day 12	1997	5 50/4	I.M.
Þ	Exami		4a. Fecility Name (If not institution,			002			4b. City, To	wn, or Lo	cation of Deeth	4c. Coun	ty of Deeth		
			Manor Care-Rux	on					То	wson		Ba	ltimo	re	
	Funeral			3. Sex 1 ☐ M 2 ဩ F	7. Age (In yrs.		Months	1 Yea	r If Under		8. Date of Birth (Month, Dey,	Year)	9. Birthp	olece (State or	Foreign
	Director		214-36-9872	ID W ZA	86	Yrs.					Sept 3			land	
	pud *_		Usual Residence of Decedent  10a. State  10b. County		10c C	ity, Town or L	ocation				•			Od Incide Cib	. I imala.
	faryli sho	5			100.0									0d. Inside City	
	28a-	Director	Maryland Balt: 10e. Street end Number	Lmore		Parkv	ille 10f. Zip	0-4-				0 0'''			XX.
	with with	ā							0.4		_   '	0g. Citizen o	AALIet Con	itry r	
	leath	Funeral	3004 4th Avenue		edent Ever in U	J.S. 13		212:		inin? (Sne	eclfy Yes or No-	USA	ace - Americ	en Indien	
0	r iter	F	1 Never Married 2 Marrie	Armed F	orces?	,,,,,	If Yes, spec	ify Cui	ban, Mexice	n, Puerto	Ricen, etc.)		ack, White,		
21215-0020	72 hours after death with the Maryland "natural", or items 23s or 28s-f show calcal Examinar must be notified at	by	3 ₩idowed 4 Divorced	If Yes, Gi Year or D	ive		1 ☐ Yes 2	2 ₹ No	Specify:			Spec	ity: Whi	ite	
2-0	72 ho	Completed	15. Decedent's	Educetion		16e. Dece	dent's Usue	Occu	pation			16b. Kind of	Business/In	dustry	
21	C 3	Pie	(Specify only highest Elementary/Secondary (0-12)	Gollege (		life.	DO NOT us	k done e retir	e du <i>ring m</i> os ed)	t of worki	ng				
21		50	12	n,	,	Lib	rarian	ı As	ssista	nt		Educ	ation		
pu	be filed tal Hyg d othe event,	Be	17. Fether's Neme (First, Middle, L	est)					18. Mothe	er's Name	(First, Middle, M	Maiden Sume	me)		
yla		2	Leroy	Russ	sell				M	elan	ie	M	ercer		
Maryland			19e. Informant's Neme/Relationsh	p (Type, Print)		19b. Meili	ing Address	(Stree	et end Numb	er or Rura	l Route Number	, City or Tow	n, Stete, Zip	Code)	
	s 1 and if Health item 27 i		R. Jeffery Roo	/Son		300	4 4th	Ave	enue,	Balt	imore, N	MD 21	234		
0	of of		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	B □ Removel from	Stete 20b.	Place of Disponentery, cre	osition (Nem metory or ot	ne of ther pl	ace)	1	Date	20c. Location	- City or To	wn, Stete	
Baltimore,			4 Domation 5 Other (Spe			rroll	Cremat	io	n Serv	ice7	/14/97	Hamps	tead,	Maryla	nd
Sal	Departm Departm Importar any inju		21. Signature of Funeral Service L	of the last	ul-				ess of Fecili ineral		^				
_	00760		Bryan W. Cla	iry	1						, Timoni	ium, M	D 210	093	
			23a. Part1 Enter the disease, or o shock, or heart failure. List o	omplications that only one cause on e	caused the dear									Approximate Intervel Between	een
2	Physician						. 1	_	+ +	~				Onset end De	eath
	/Medical Examiner		Immediete Ceuse (Final disease or condition resulting in death)	e. C	ever	6 W	Vall y	m	rile	2			1	MIN	146
			resulting in death)		990 to (	or es e conse	quence of):							1	
	ped isit	nin.		ь.	(a) (a)	1	ay	10	W				2	YCO1	11.
•	eath certificate be executed attending physician and for use as the burial-transit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury		Due to (d	or es e conse	quence of):						1	(	
68760,	be e Siciar buri		Cause. Enter Underlying Cause (Disease or Injury thet Initieted events	C									i		
89	phy:	Medical	resulting In deeth) Lest		Due to (c	or es e consec	quence of):								
×	certifu nding use a	M		d									1		
Bo	death le atter ed for u	Physician/	Death Other deathers are the								1				
P.O.	that the deathed by the atte	hys	Part II. Other significant condition	s contributing to di	eath but not res	sulting in the u	inderlying ce	ouse g	iven in Pert I	•				the cause of	
		by PI									1 U Ye	es 2 No	3 Prol	bably 442V	Inknown
Division of Vital Records,	law requires as been sign s 2 should be	ᇫ									24a. Wes er	n eutopsy	24b. We	ere eutopsy fin	dings
8	w require been si should	ete									perform	ned?	CO	eilable prior to mpletion of cer deeth?	use
Be	0 - 0	Completed									1□ Ye	s 20 No			la.
ta	m: The	a)	25. Was cese referred to medical						26 Place	of Dooth				Yes 221	,0
7	2	B	examiner? 1 ☐ Yes 22 No	Hospitel:	Inpatient 2	ER/Outpetier	ot 3□ DO	A O	hor		(Check only one ne 5 ☐ Reside		har /Specifi	el.	
0	1663		27. Menner of Death	28e. Date	of Injury	28b. Time o		Bc. Inju		T-	28d. Describe ho			//	
b		atio	1 12 Naturel 5 Pending 2 Accident investiga		th, Day Year)	Injury	М	1 [	Yes 2	No					
VIS	1018	Hice	3 ☐ Suicide 6 ☐ Could no determin	ad 286. Place	of Injury - At h	ome, farm, sti	reet, fectory,	office	· ·	2	28f. Location (Sti	reet and Nun	ber or Rura	Route Number	er,
ā	a alter	Certificati	4 🗆 nomicide	buildi	ng, etc. (Specif	(Y)	_				City or Town	, State)			
	hour hour inera		29a. Certifier 1 Certifying (Check only 2 Medical Fo	Physician: To the	best of my kno	wledge, deati	n occurred e	t the t	ime, dete en	d plece, e	nd due to the ca	ause(s) and n	nenner es st	eted.	
	To the Hospital or within 24 hours all To the Funeral Dis completely filled in	edicai	one) 2 Medical Ex	aminer: On the be end man	esis of examina	mon ena/or in	vestigation,	ın my	opinion, dee	m occurre	e et the time, de	ere end plece	, end due to	tne ceuse(s)	
	To To To To	2	29b. Signeture end title of certifier	1 .1		1/M	<b>3</b> €°	Licen	se number	2/	25	9d. Date sign	ed (Month,	Day, Year)	
				5. X	111	111	10	4	4+	50		+-1	5-9	7	
	6		30. Neme end eddress of person wi	o completed caus	e of deeth (Iten	n 23a) (Type,	Print)			11	1 1		1/ 5		
	*		7600 05kg	NIOY	INC		104	15/	n	1	01 21	20.	4-1	DRAYN	IAN
	Sta		31. Date filed (Month, Day, Year)		egistrar's Signe								,	AKKA	1
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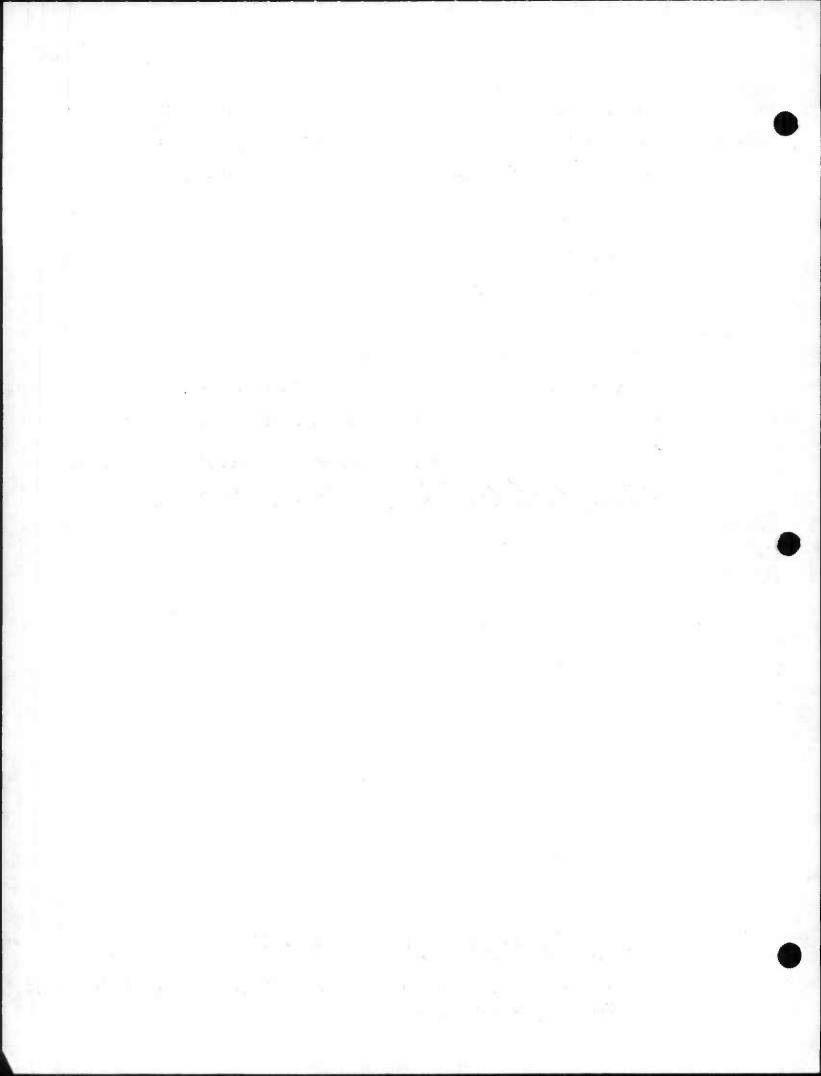
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State of Maryland / Department of Health and Mental Hygiene 97 2

21408

						Certificate of	of Death	F	Reg. No.		
į.	Dhusia		1. Decedant's Nama (First, Middla, La	st)				2. Data of Das	ath		3. Tima of Death
J	Physic /Medi		Anna E. Rolka	l				July	10 1	997	8:00 A.N
ě.	Exami		4a. Facility Nama (If not institution, given	a streat end numbe	or)		4b. City, Town, or I				-
	Self L	JO	3557 Elmora Ave	•			Baltimore	City	N/A		
	Funeral Director		219-03-344)	Sex 7. / I□M 2/21 F	Aga (In yrs. lasi 84	Yrs. If Under 1 Ye Months Day		8. Data of Birth (Month, Day 8/2/19	h v, Yaar) 912	9. Birthi Cour MD	piace (Stata or Forai ntry) )
	and		Usual Rasidence of Dacadant  10a. Stata 10b. County		10c. City, T	own or Location					10d. Insida City Limi
	eth with the Marylar 123a or 28a-f show	ctor	MD N/A		1.0	Baltimore Ci	ty				1 Z Yas 2 □ N
	ith th	Dire	10e. Street and Number			10f. Zip Code	a		10g. Citizan of	Whet Cour	ntry?
	23a	ie	3557 Elmora Ave	•			21213		U.S	.A.	
21215-0020	filed within 72 hours efter deeth with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Exercinet must be notified at	by Funeral Director	11. Marital Status  1 □ Naver Merriad 2 ☑ Marriad  3 □ Widowad 4 □ Divorcad	12. Wes Dacedar Armed Forcas 1 Tas 2 I If Yes, Giva Yaar or Datas	No	13. Was Decedent of If Yas, specify C	of Hispanic Origin? (S) uben, Maxican, Puant No Specify:	pacify Yes or No- Rican, etc.)	14. Rad Bla Specif	ck, Whita,	
20	72 hours "natural",	ted	15. Decedant's Ed	ducation	1	6e. Decadant's Usual Occ	cupation		16b. Kind of B		
21	an e	Be Completed	(Spacify only highast gra Elamentary/Secondary (0-12)	College (1-4o	r 5+)	(Giva kind of work do lifa. DO NOT use ret	na during most of wor ired)	king			
	ygien F. Stern	Con	7	N/A		Salesperson	n		Retai	1	
Pu		Be	17. Fathar's Nama (First, Middle, Last,				18. Mothar's Nan	ne (First, Middla,	Maidan Sumar	na)	
yla	ould be Mentai erked o	2	John Sienkewich				Cather				
Maryland	2 sh end ls m		19a. Informant's Name/Relationship ( Anthony Rolka	Typa, Print)		19b. Mailing Address <i>(Stre</i> 3557 Elmora		ral Routa Numbe timore,			Code)
Baltimore,	permit. Peges 1 end Depertment of Heeith Important: If Item 27 any injury or other to pace.		20a. Mathod of Disposition			a of Disposition (Nama of		7,007,000	20c. Location		own, Stata
Ë	ent o nt: If I		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Othar (Spacif	Removal from State	EL	d Heart of	27.75	Western.			
H	permit. Peges Depertment of I Important: If ite any injury or of		21. Signatura of Funaral Servica Liour		Sacre	22. Name and Add		1/12/9/	Dalting	ore C	nty., MD
ä	Depermination of the second of		1	100.	LX	B. Dabros	wski & Son	Funeral	Home		
			23a Part Enter the disease of som	clearly that are	sugar	2818 E.	Baltimore	St. Balt	imore.	MD 2	
			23a. Part1. Entar tha disaasa, ok.com shock, or haart failura. List only	ona causa on aach	ne death. L	to not enter the mode of d	lying, such as cardiac	or respiratory arr	est.		Approximate Interval Between
	Physician / /Medical		Immediata Causa (Final	5		1.					Onset and Death
	Examiner		disaasa or condition rasulting In death)	. 00	rona	ly alteri	1 desea	B			
		e e			Due to (or as	a consequence of):					
	petr I	Medical Examiner	•	b	- (	/ . "	8				
Ć,	erlificete be executed ding physician end se es the buriel-trensit	Exa	Sequantially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disaase or Injury		Due to (or all	a consequence of):					
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. ,	12		30. Name and address of person who o		death (Itam 23a	(Typa, Print)	m Dada		0	1.1	10 7/2/

State Registrar



State of Maryland / Department of Health and Mental Hygiene

21409 Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Death 3. Tim f th Month LY 8, Dey 1997 Yeer **Physician** 7:40 AM **JOSEPH** SMITH /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore IVY HALL NURSING HOME Baltimore County Hours Min. 8. Date of Birth (Month, Dey, Yeer) 5. Sociel Security Number 7. Age (In yrs. lest birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** XMM 2DF Months Days 219-01-4579 80 Yrs. Dec. 8,1916 Director Maryland Usual Residence of Decedent deeth with the Maryland 10a. State Show 10b. County 10c, City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shovedical Examiner must be notified at Baltimore Overlea/Fullerton 1 ☐ Yes 3 No Director Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21206 3 East Elm Avenue USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever In U,S. Armed Forces? 14. Race - American Indian. permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or item any injury or other traumatic event, the Medical Propose. Black, White, etc. Yes XX No 1 Never Married 2 Married 21215-0020 1 ☐ Yes XX No Specify: Specify: White þ 3 ☐ Widowed > ♥ ♥ Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th grade N/A Painter Self-Employeed altimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Louis Smith Genevieve L. Eichelberger 2 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Peggy A. Sadowski 3403 Upton Circle Baltimore, Md. 21234 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremetion 3 ☐ Removal from State Gardens of Faith Cemetery 7-11-97 Baltimore, Md. 4 ☐ Donetion 5 ☐ Other (Specify) use of Funeral Service 22. Name and Address of Fecility Lassahn Funeral Home 23a. Part1. Enter the disease, or complications that cabsed the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examiner 110 The law requires that the death certificete be executed buriel-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or InJury that initiated events resulting in deeth) Lest P.O. Box 68760. Physician/Medical the Due to (or as e consequence of) for use es Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown signed t Records. þ 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Was an autopsy page 2 1 Yes 2 LNG 1 ☐ Yes 2 of Vital Physician: director, Be 25. Was case referred to redical exeminer? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA this in by the funerei 27. Menner of Death 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred After Division or Attending 5 Pending investigation 1 Naturel s after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled filled Hospital 1 Certifying Phyeician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner stated. 29a. Certifier Medicai (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Micoco, 30. Negre and eddress of person who completed cause of deeth (Item 23e) (Type, Print) ACTOR ROAD PAUT- NEW 21234 PATRICIO AC 32. Registrar's Signature 31. Dete filed (Month, Day, Year) State lie Davidson JUL 1 5 1997 Registrar

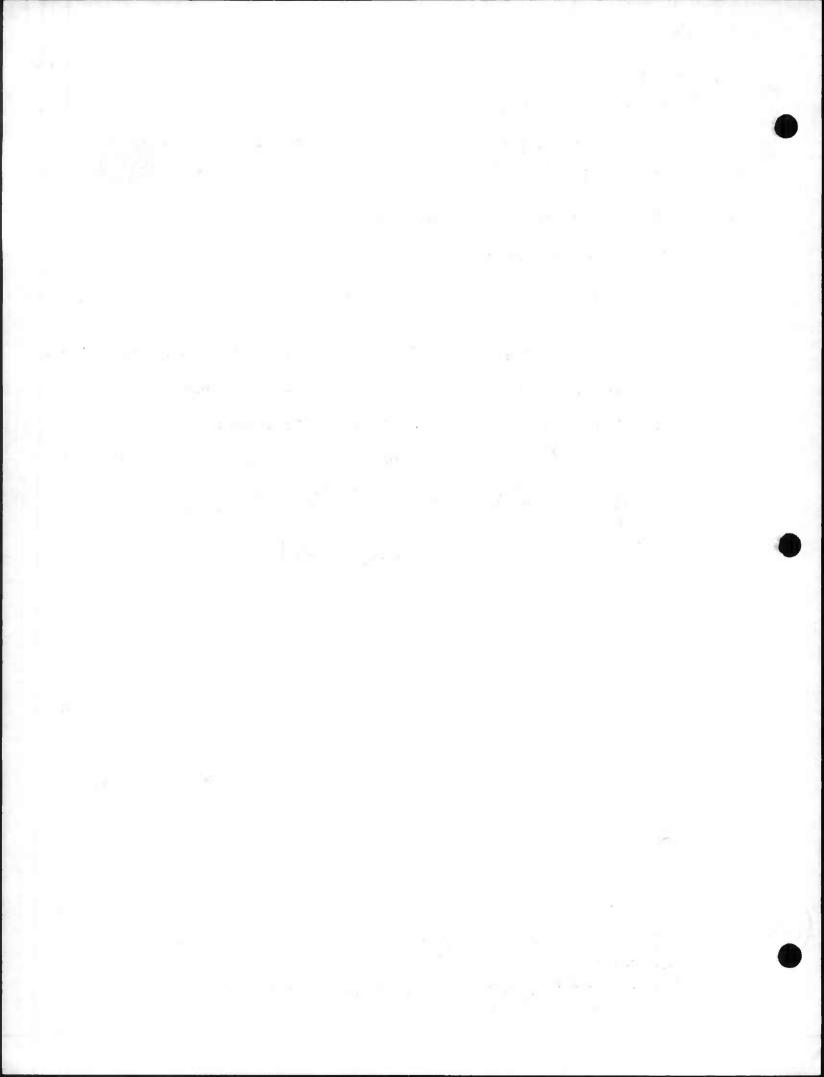
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1	Funeral Director		5. Social Security Number 215-54-7525  Usual Residence of Decedent	M 2□F	ge (In yrs. le 45	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of B (Month, D Feb.	10, 195	9. Birthplac Country 5 2 M c	e (State or Foreign
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	23a 23a	ral	2972 Mossdal	e Drive			370	013		USA		
020	after or Ite	by Funeral Director	11. Marital Status  1 ☐ Never Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 H If Yes, Give X Year or Dates:			Vas Decedent of I Yes, specify Cub I□ Yes 2☑ No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)		ce-Americen ck, White, etc b: Whit	3.
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Z	2 should be and Mantal is marked o aumatic eve	٦̈	Orville C. S  19a. Informant's Name/Relationship			10h Mailin	a Address (Street	Maud end Number or Ru	Wils		State Zin C	ada)
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Ē	Pagas nant of i		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Specific	Removal from State  y)			n Cemet	-	7-12	Nashy	ville,	TN
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lice	1500 Vo	0			V. Jenki		Sons		
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Division	ptil or Attanding Physics after death.	Certification:	3 Sulcide 6 Could not be determined	28e. Place of Inj	ury - At hom c. (Specify)	ne, farm, stre	eet, factory, office			(Street end Numi own, Stete)	ber or Rural R	oute Number,
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JA	Ton	ž	29b. Signature and title of certifier	/	,, ſ	\	29c. Licens	se number		29d. Date signe	d (Month, De	y, Yeer)
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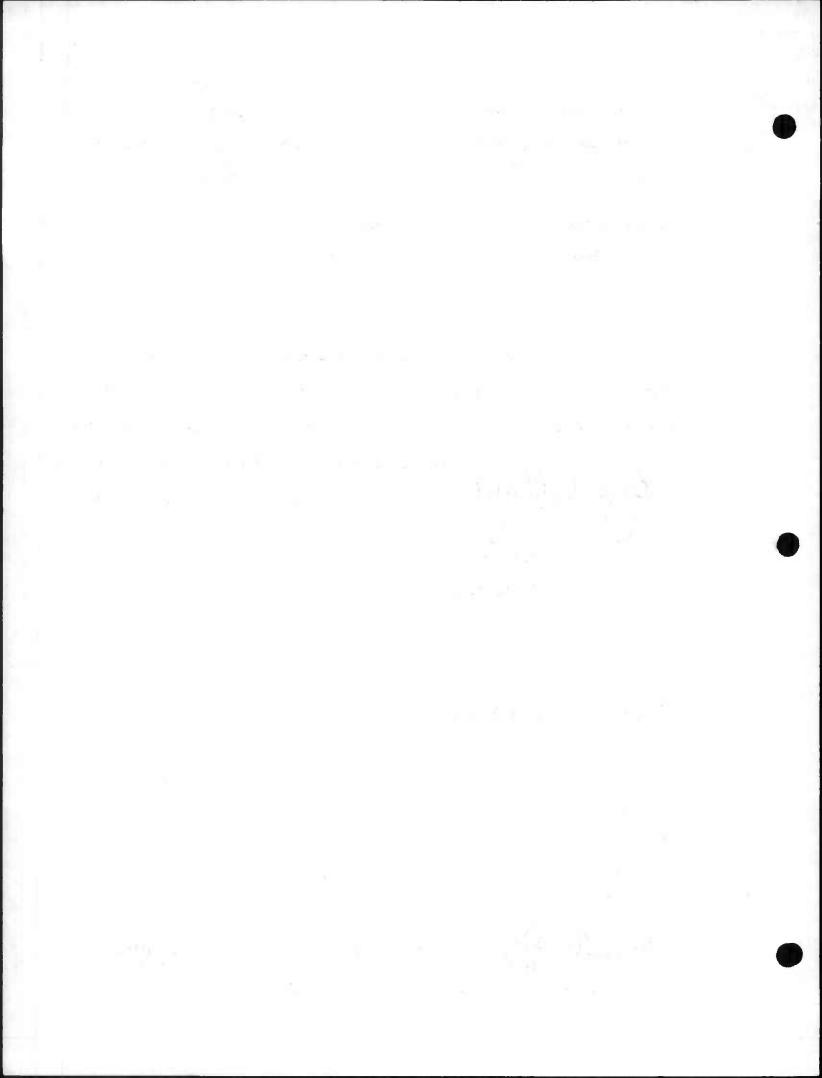
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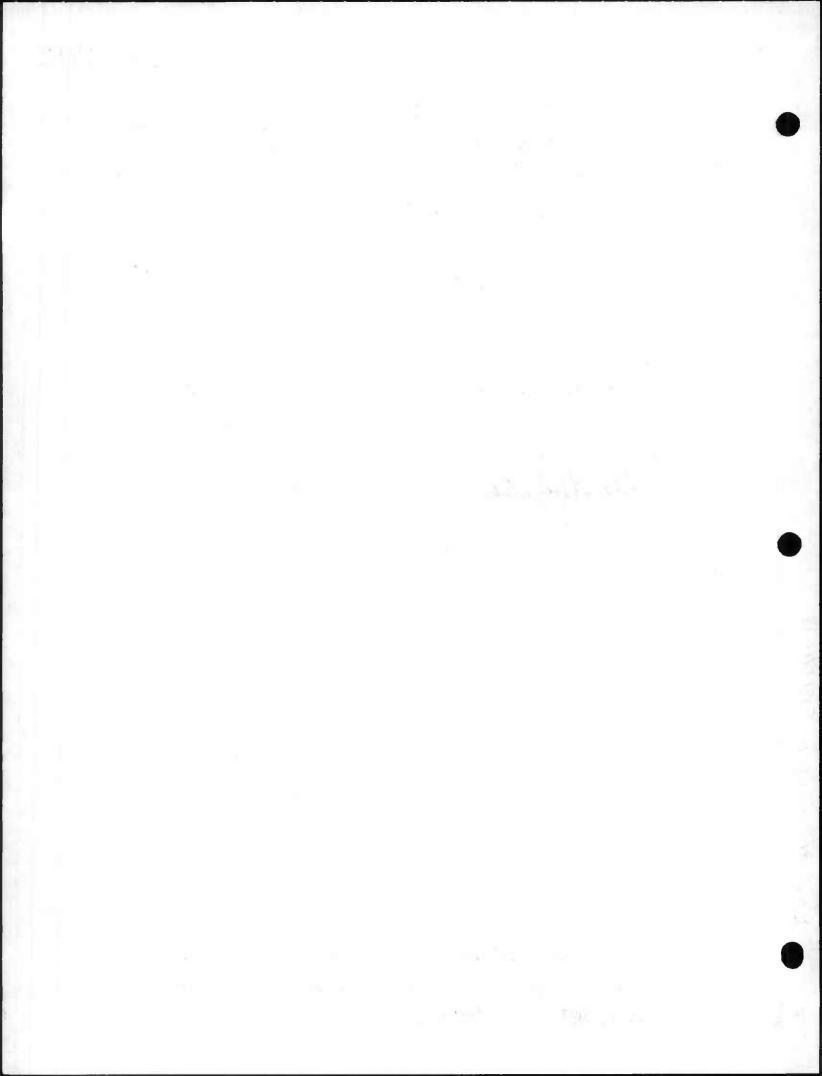
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1	>	cert		examiner?	-	Hospital:				Ott	oer.		11	-				
12   Nature   2   Accident   3   Suicide   4   Homicide   5   Pending investigation   6   Could not be determined   29e. Certifier (Check only one)   29e. Certifier (Check only one)   29e. Signature and title of certifier   29e. Signature and eddress of person who completed cause of deeth (Item 23e) (Type, Print)   Dominick Memoli, MD 9 Schilling Road, Hunt Valley, Maryland 21030   State   31. Determined   12   Month, Day, Year)   32. Registrar's Signeture	ō	this ald								DUA	4 L N						'y)	
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State of Maryland / Department of Health and Mental Hygiene 97 214 12

					e of Death		Reg. N	lo.			
Physician /Medical	1. Decedent's Name (First, Middle, Last)  Lavern Cecelia Smithell					2. Dete of D Month		еу О	Yeer 1997	3. Time of 1	
Examiner	4a. Fecility Neme (If not institution, give				4b. City, Town	, or Locetion of De		c. County			
	Union Memorial				Balt	imore			N/A		
uneral rector	5. Social Security Number  6. Se 212-36-2246  Usuel Residence of Decedent	TM 2 VE	(In yrs. last birtho	Months	1 Year If Under 24 Days Hours	Hrs. 8. Date of (Month, AUG				ece (State or try) yland	
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ctor	MD Anne A	runde1	G1en	Burni	е					1 ☐ Yes	
ritems 23a or 28a-1 st	10e. Street and Number 10f. Zip Code 10g. Citizen of V 21061 USA								Vhet Coun	try?	
any injury or other traumatic event, fre Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Maritel Status  1 □ Never Married 2 ▼ Marrled  3 □ Widowed 4 □ Divorced	□ Never Married 2 Married Armed Forces?  1 □ Yes 2 No If Yes, Give			J.S. 13. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri  1 ☐ Yes 2♥ No Specify:				city Yes or No- lican, etc.)  14. Race - American I Bleck, White, etc.  Specify: White		
ed b	15. Decedent's Edu	Year or Dates:					16b. Kind of Business/Industry				
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27 Is	Charles W. Smit									Code)	
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y inju	21. Signature of Funeral Service Licens	9 111	Hetto	22. Name er	d Address of Fecility					ישורי	
E & 8	Edward A. Gregorchik Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228										
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Aedical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause, (Disease or injury								2doy 3do		
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etached for use Physician/I	Pert II. Other algnificant conditions cor	ntributing to death but n	not resulting in th	e underlying o	ause given in Pert I.	23b. D	d tobacc	o use con	tribute to	the cause of	
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						24a. W	24a. Wes en eutopsy performed?		eve	re eutopsy fin ilable prior to apletion of ce	
pe 2 should mpleted						_ ре	101111001		of d	eeth?	
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actor, page 2 shoul Be Completed	25. Was case referred to medicel examiner?						Yes 2	2.⊠No			
If director, page 2 shoul	examiner? 1 ☐ Yes 200 No	lospital: 1 🗵 Inpatient			A Other: 4 Nursli	1 [ Deeth <i>(Check onli</i> ng Home 5 ☐ Re	Yes 2 y one) sidence	6 □Othe	1 □	Yes 2月1N	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** Smith 2 sabelle /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Villa St. Michael Baltimore City Baltimore If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□M 2₽F 78 Yrs. Director 117-12-9313 2, 1919 Feb. Pennsylvania Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "natural", or items 23s or 2se. \*\* 2000. 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Glen Burnie 1 ☐ Yes 24 ☐ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 18 Jackson Avenue 21061 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 21 No White þ Specify. 3 ☐ Widowed 4 ₺ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 0 Sales Clerk Department Store 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Albert Cioccia Pasgualina Basilone 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7012 Bexhill Road, Baltimore, Maryland 21207 Lill Miller/daughter 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 Donetion 5 ☐ Other (Specify) Signature of Funerel Service Licensee Ronald S. 22. Name end Address of Fecility
State Anatomy Board, 655 W. Baltimore Street Wade Director Baltimore, Maryland 21201 Pert 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Physician Immediate Ceuse (Finel diseese or condition resulting in death) /Medical Omin **Examiner** Due to (or es e consequence of): Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest Due to (or es e consequence of): Box 68760 Due to (or es e consequence of): The law requires that tha death certifical Pert I. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed this certificate has PRESSION 1 ☐ Yes 2 ☐ No 1 Tyes 2 No al or Attending Physician: T s after death. I Director: After this certificat of in by tha funeral diractor, pi 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Mursing Home a No Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28e. Dete of Injury (Month, Day Year) 27. Menper of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 □ Yes 2 □ No 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral D Medicai 29a. Certifier ഺ 🖸 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) and menner es steted. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) end menner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

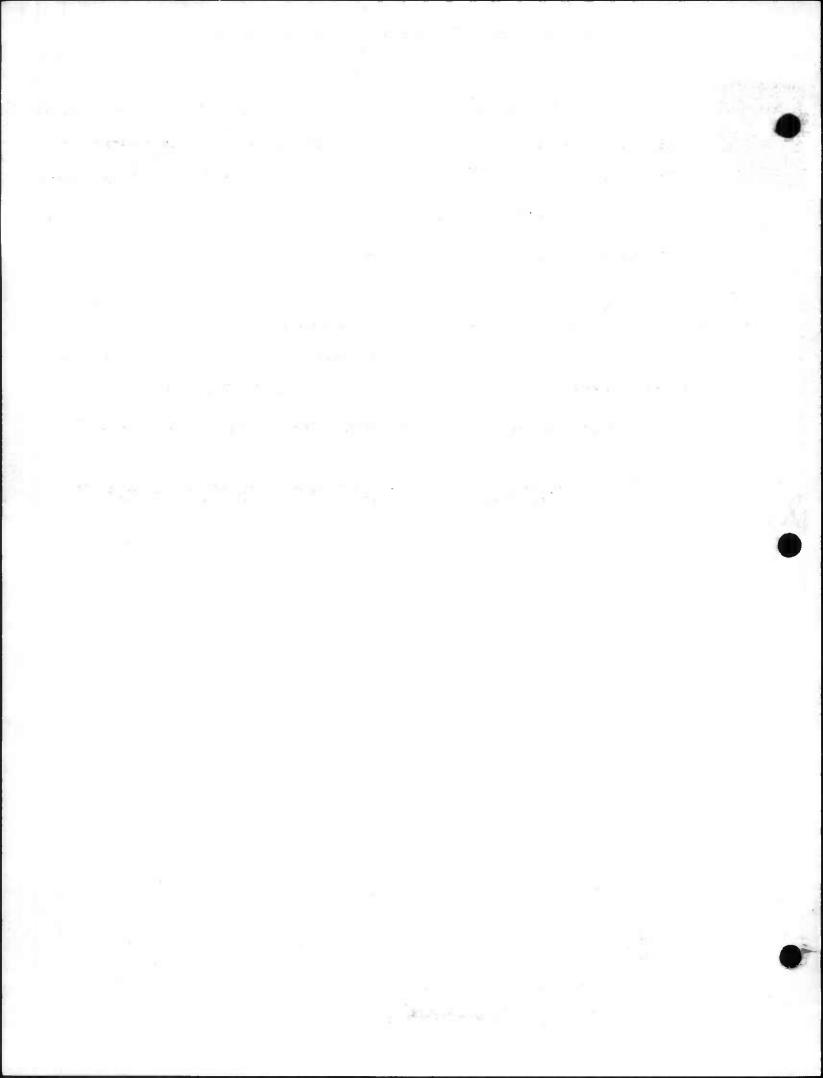
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31. Dete filed (Month, Day, Year) 5 1997

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30. Neme end address of person who completed

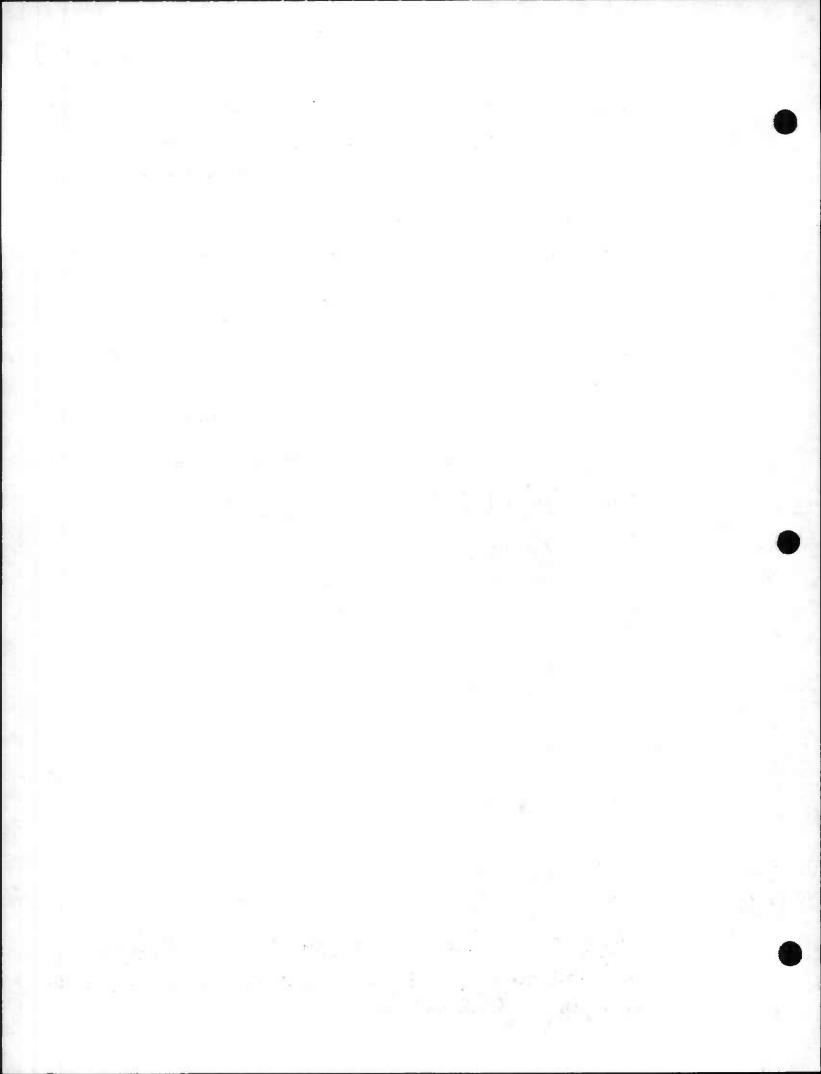
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/Medical AFT FRYN			KATHRYN. F.				JULY	19-	1997 11	30 AM		
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			5. Social Security Number 6. Sax	EDICAL CENT		if Under 1 Year	Towson		-	rimore	0	
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	or 28g	Director	10a. Streat and Number 10f. Zip C						10g. Citizan of \	0g. Citizan of What Country?		
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dea dea		Funeral	11. Marital Status	12. Was Dacedant Ever in U	J,S. 13. W	as Decedant of F	Hispanic Origin? (S an, Maxican, Puar	Specify Yes or No-	14. Rac	ca - American Inc	lian,	
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Bal	permit. Pages Department of I Important: If Ite any injury or of		21. Signature of Funaral Service Licensea  22. Name and Address of Facility:  HARTLEY MITTER FUNERAL HOME									
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	Physician /Medical Examiner	ner	Immadiata Causa (Final disaasa or condition rasulting in death) a		BDUV a or as a consequ		emat	ома			HOUS	
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	Vith Fo th	Me	29b. Signatura and titla of cartifiar	11		29c. Licans	canse number 29d. Data signad (Me				rear)	
			June	Khoz		1120	7-13-97 D, TOWSON, MD 21204					
,	7		30. Name and addrass of person who co	mplated causa of death (Ital	n 23e) (Type, P	rint)			• )			
_			FRANCIS KHOO		20 YOR	K ROAL	Towso	N, MD	2120	4		
	Sta	te ar	31. Data filed (Month, Day, Year)	Fagistrar's Sign	atura							

State of Maryland / Department of Health and Mental Hygiene 97 2 14 15

					Ce	ertifica	ite of	Death		Reg. N	0.	-	
	Physical Control of the Control of t		Decedent's Name (First, Middle, La.	st)					2. Date of	Death		3.	Time of Death
J	Physic /Medi		HILDA	MARGARET			1	TEWS	JULY	Ç	<sup>ay</sup> , 199	97	3:00 AM
9	Exami		4a. Facility Name (If not institution, give	e streat and number)				4b. City, Tov	vn, or Location of De		c. County of D	Death	
1			NORTH ARUNDEL	HOSPITAL ASSN				GLEN	BURNIE	P	ANNE AR	RUNDEI	
	Funeral Director		5. Social Security Number 6. S  2.14-20-1329  Usual Residence of Decedent	6ex 7. Age (In yrs. 1 ☐ M 25xF 89	V	y) If Und Month	ar 1 Yaar s Days	If Under 2 Hours	Min. 8. Date of (Month, Aug.	Birth Day Year 21,			(State or Foreign
	land wo		10a. State 10b. County	10c. Cit	y, Town or I	Location				_		10d. I	nside City Limits
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	ath with s 23a or	rai Dir	409 Dobbins Lar			2	ip Code 1122			Un	itizan of What		es
0050	72 hours after death with the Maryland natural; or items 23a or 28a-f show digal Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorcad	12. Was Dacedent Ever in U Armed Forcas? 1 ☐ Yes 2 2 No If Yes, Give Year or Datas:	,S. 13			lispanlc Orig an, Mexican, Specify:	in? (Specify Yes or Puerto Ricen, atc.)	No-	Specify:	Amarican Ir Vhita, atc. White	
5	72 hours "natural", adical Exa	etec	15. Decedent's Ed (Specify only highest gra	ducation ada completed)	16a. Dec	edent's Us	ual Occup	ation during most	of working	16b. F	Kind of Busine	ess/Industr	у
21215-0020	e filed within al Hygiena. other then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		oo NOT emak		during most d)		70	wn hon	ne	
pu	al Hy other	Be	17. Fathar's Name (First, Middla, Last)					18. Mothar	's Nama (First, Midd	lla, Maidai	n Sumame)		
Va	Mant Mant Marked Price	2	John A. Schwai	rtz				Car	rie Tuck	er			
Maryland	ges 1 and 2 should be filed within 72 ho to f Haath and Mantal Lygiena. If itam 27 is marked other than "natur or other traumatic event, the Medical		19a. Informant's Name/Relationship (1 Joan Ann Sebalo	***					or Rural Route Nur e Pasede				
Baltimore,	permit. Pages 1 and Department of Haalth Important: If itam 27 any injury or other ti once.		20a. Method of Disposition  1X Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	Place of Dispendence	ematory or	othar plac	,	Date y 7/11		ocation - City		State Marylan
Balti	permit. Page Department of important: If any injury or once.		21. Signature of Funeral Socica Lican		, ;	22. Name a	and Addre	ss of Facility Fune:	ral Home	of	Lanso	down	_
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	Examiner		diseese or condition resulting in death)	W	r as a cons		١.					30	lays.
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-6	executed and al-transi	Examiner	Sequantially list conditions, if any, laading to immediate	D	r as a conse							100	Coup.
68760,	death certificate be executed e attending physician and of for usa as the burial-transit	Medicai I	Sequantially list conditions, if any, laading to immediate cause. Enter Undertying Ceuse (Disease or injury that initiated events resulting in death) Last	cDua to (or	r as a conse	iquance of	):						
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	daat ed for	sicia	Part II. Other algnificant conditions co	ontributing to death but not res	ulting In tha	underlying	cause giv	en in Part I.	23b. D	d tobacce	o uae contrib	ute to the	cause of death?
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	ding h. After fune	atlon:	27. Menner of Death  1 Natural 5 Panding 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of M	28c. Injun Wor	yat k? Yes 2 □ N	28d. Describ	e how inju	iry occurred		
Division	tal Atten	Certification:	3 Suicida 6 Could not be determined	28e. Placa of Injury - At he building, etc. (Specify	ome, farm, s	tr <i>ee</i> t, facto	ry, office			(Street a. own, State	nd Number or e)	<i>Rural R</i> ou	ite Number,
((	14)	edical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	yalclan: To the best of my know ilner: On the basis of examinat end manner steted.	wledge, dea ion end/or li	th occurred nvestigatio	d at the tin	ne, date end pinlon, deeth	place, and due to the cocurred at the time	e ceuse(s e, dete en	) and manner d place, and c	r es stated due to the	cause(s)
/	Tale of the contract of the co	ž	29b. Signature and title of certifier			29	c. Licens	e number		29d. Da	ste signey (Mo	onth, Day,	Year)
	.0		HATE	MD			7	397-	7	7	191	197	7
	10		30. Name and address of person who co	completed cause of death (Item	23a) (Type	Print)	2	DRIVE	? E. GLON B	infi	IE . M	p 2	1061
	Sta	te	31. Data filed (Month, Day, Year)	32 Aprilstrade Signat	ture Ranc	lesse						-	

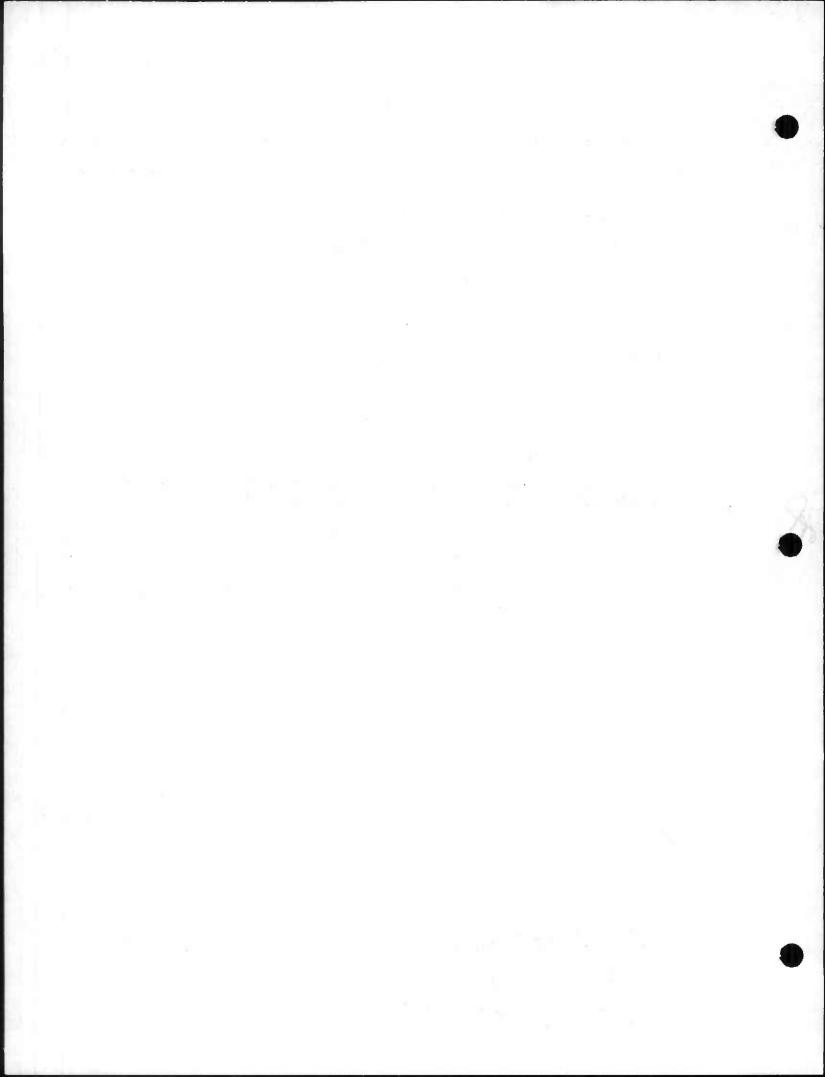


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Curtis homas 9:40AM July , 1997 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Joseph Ritchie Hospice Baltimore Baltimore City | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | Sept. 16, 1958 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1₩ M 2□ F Yrs. Maryland Director 213-80-0393 Usual Residence of Decedent death with the Maryland 10e. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Maryland Baltimore City Baltimore Director 1 No 2 No 10e. Street end Number 10g. Citizen of What Country? ö 828 N. Eutaw Street Items 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces?unknown 1 □ Yes 2 □ No If Yes, Give Year or Detes: 11. Marital Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, permit. Fages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If team 27 is marked other then "natural", or iten any injury or other traumatic event, the Medical Examines once. Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade Elementery/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unknown unknown 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) unknown unknown 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 Other (Specify) in State 21. Signature of Fundral Service Licensee Ronald S <sup>22</sup> Name and Address of Fecility State Anatomy Board, 655 W. Baltimore Street Warde. Director Baltimroe, Maryland 21201 Pain 1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heert failure. List only one ceuse on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last P.O. Box 68760. Due to (or es e consequence of) or Attending Physician: The law requires that the deal Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 Unknown s been signed to should be dete Records, þ Completed 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? is certificate hes director, pege 2 After this certificate 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes cese referred to medice 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Nother (Specify) HO 5 PIC C 1 Yes 2 No Certification: To filled in by the funeral 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No efter death 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hoapital
within 24 hours e
To the Funeral C Medicai 29a. Certifier 🔁 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end piece, end due to the cause(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner steted. 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) 97 8 of person who completed cause of deeth (Item 23a) (Type, Print) Botton Ballimore 31. Dete filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

JUL 1 5 1997



State of Maryland / Department of Health and Mental Hygiene

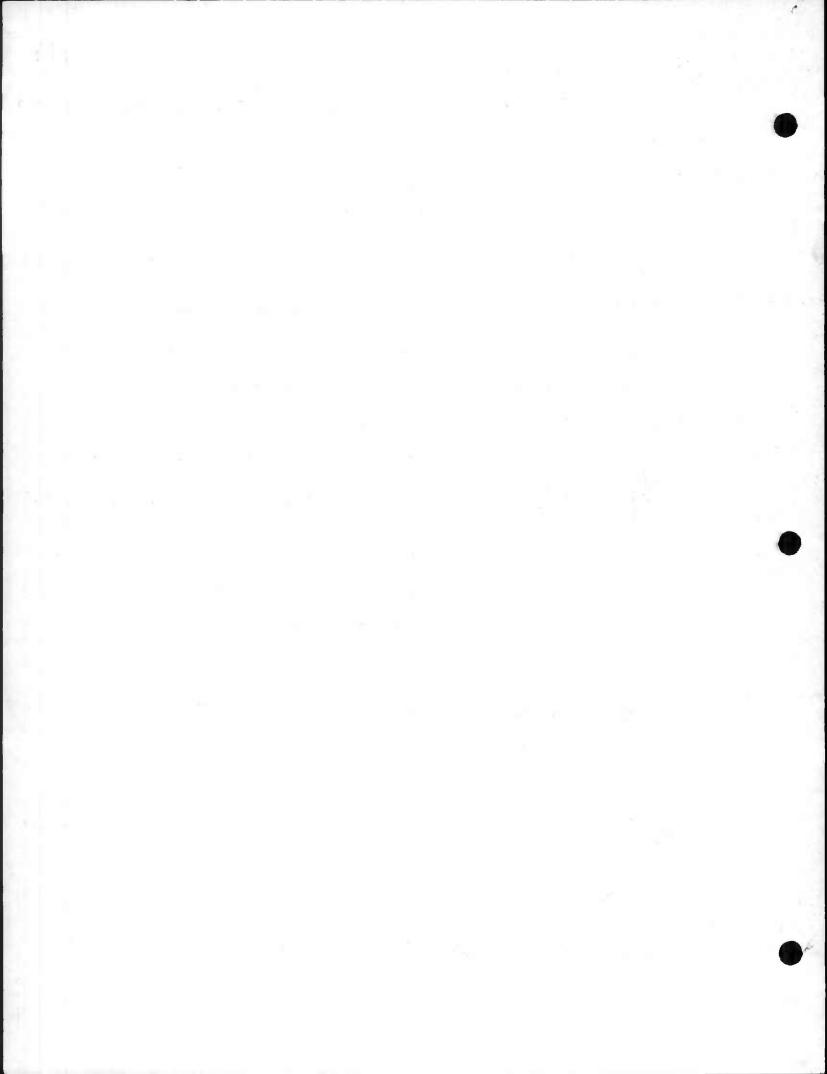
ITEM#11 PER F.H. FLM#G749 7/18/97 J.A. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3. Time of Death 11:10 AM **Physician** TALLEY, JR. COLLINS Ju /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner MERCY HOSPITAL BALTIMORE N/A | H Under 1 Year | H Under 24 Hrs. | 8. Data of Birth | Months | Deys | Hours | Min. | 10/08/1929 5. Sociel Sacurity Number 9. Birthpleca (Stete or Foreign Country)
Maryland 7. Age (In vrs. lest birthday) **Funeral** 187 M 2□ F Months 216-20-7040 67 Yrs. Director Usuel Residence of Decedent the Maryland 10e Stete 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD N/A BALTIMORE Director N Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 653 CHARRAWAY ROAD 21229 U.S.A. Funeral 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (XNo If Yes, Give Yeer or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, etc. 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 1 No Specify: p Specify 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) pernit. Pages 1 and 2 should be filed within Department of Health and Mantel Hygiena Important: If Item 27 is marked other than "nany Injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Transportation Manager 12th 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be Collins Talley, Sr. Eunice Means 19e. Informent's Neme/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Shirley Muldrow 653 Charraway Road, Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State King Memorial Park 7/15 4 ☐ Donation 5 ☐ Other (Specify) Randallstown, MD LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO. 21207 21. Signature of Funeral Service License Do not enter the moda of dying, such es cardiec or respiratory arrest, complications that daused only one cause on each in **Physician** /Medical Immediate Cause (Final SEPTICEMIA 2 DAYS disaesa or condition resulting in death) Examiner Due to (or es e consequence of): 1085 INFECTED GANGRENOUS 5 WEEKS buriel-trensit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted avents resulting in death) Lest Due to (or es e consequence of): end physician s the buriel INSUFFICIENCY ONE TEAR P.O. Box 68760. ANTENIAL PERIPHERAL Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown OF THE LUNG CARCINOMA Records, þ RADIATION ESOPHAGITIS 24a. Was an eutopsy performed? 24b. Wera autopsy findings available prior to completion of cause of death? Completed peen certificate 1 ☐ Yas 2 ☐ No Division of Vital within 24 hours after death.

Within 24 hours after death.

To the Funeral Director: After this certification completaly filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) STELLA MARIS Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Certification: To 28e. Dete of Injury (Month, Day Year) AT MERCY 27. Menger of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide Cartifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end placa, end due to the ceuse(s) and menner es steted.

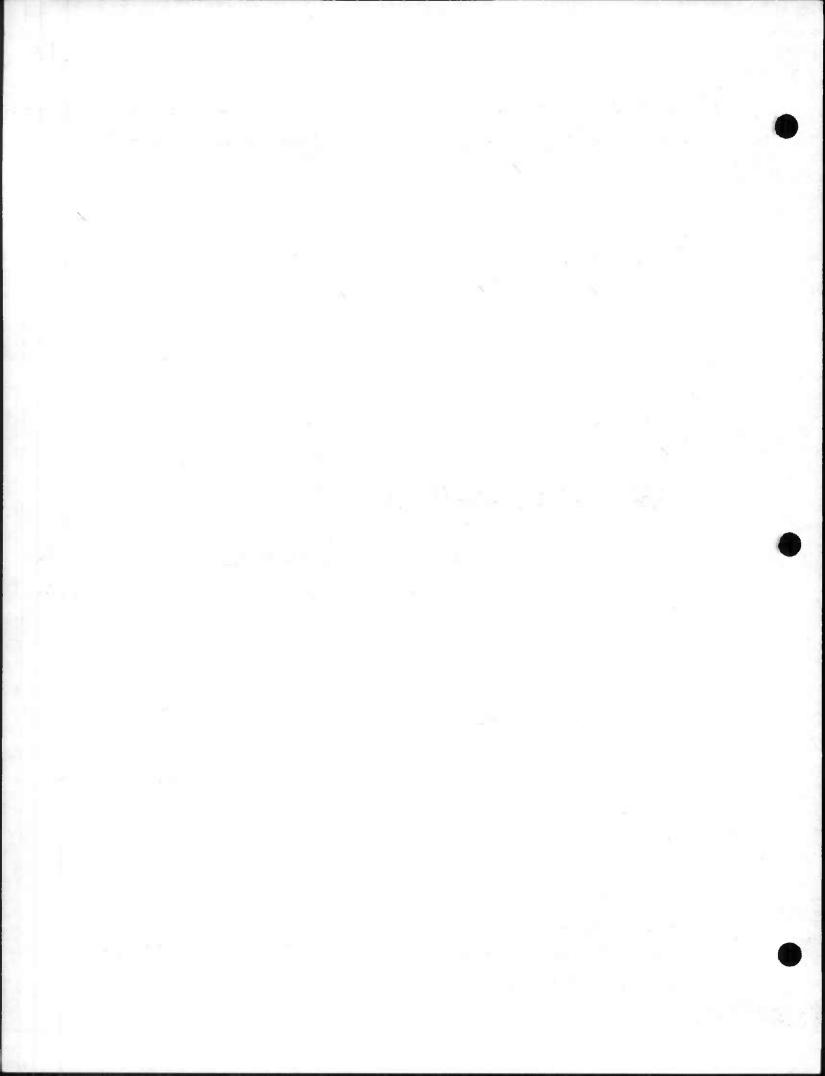
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner steted. 29a. Cartifier (Check only one) 29b, Signature and title of certifier 29d. Date signed (Month, Day, Yeer) 7-8-1997 30. Nerhe end address of person who completed cause of deeth (Item 23a) (Type, Print) BALTIMORE ZIZOZ JOSEPH D. NOTARANGELOM.D. PAUL PLACE 301 ST.

State Registrar



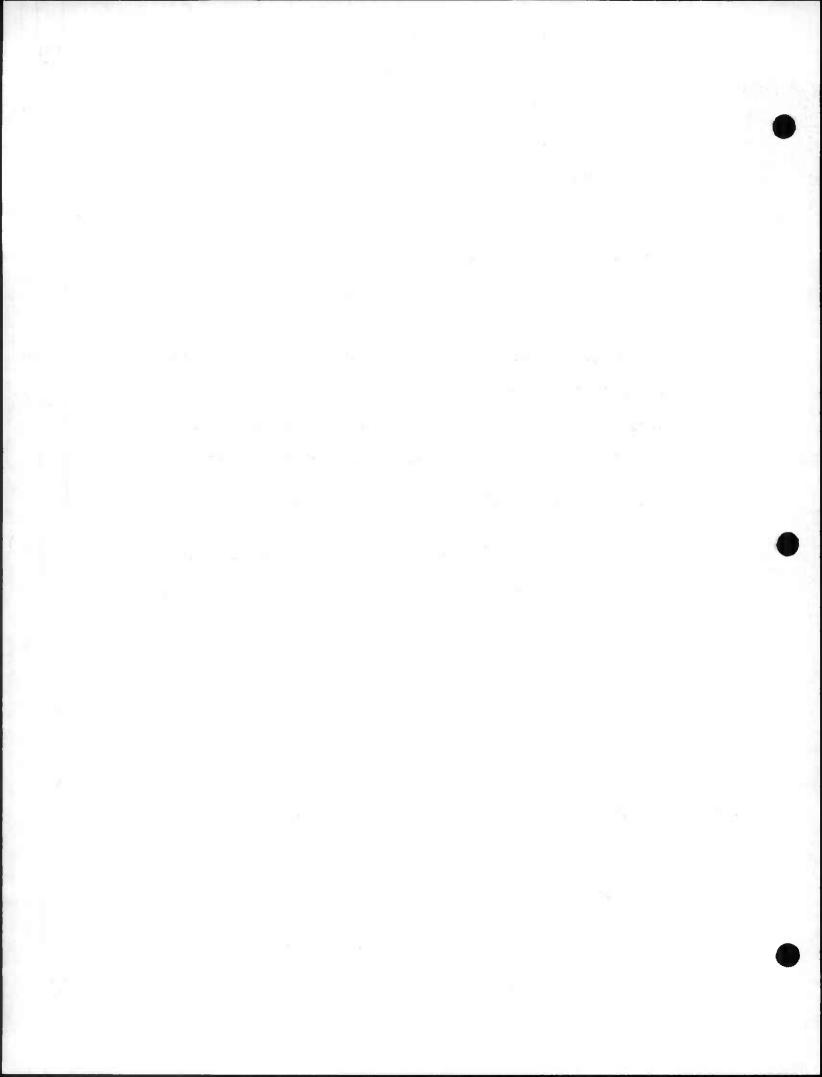
State of Maryland / Department of Health and Mental Hygiene 97 2 14 18

								Certific	ate of	Death	,	Reg. No	o.	•	lon I	
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	Funeral Director		5. Social Security Number 218-21-1722	6. Sex		7. Age (In yrs	. last birt		der 1 Year hs Deys	If Under 24 Hrs Hours Min	8. Date of Bi (Month, Di 10/3	rth ay, Yeer)	78	9. Birthp Coun MD	lece (Stete try)	e or Foreign
	70		Usual Residence of Decedent								10/3	1,17	70	1110		
	nylar how		10a. State 10b. County					or Location						1	0d. Inside	City Limits
	e Ma	cto	MD N/	A			3alt:	imore (	City						1 Z Y	es 2 No
	₩ 64 H	Director	10e. Street end Number					10f.	Zip Code			10g. Cit	tizen of W	het Coun	try?	
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Maryland 21215-0020	d within 72 hours effer deeth with the Maryland jiene. Than "naturel", or Items 23a or 28a-f show the Maddell Exam or mark by Inviting at	by Funeral	11. Maritel Stetus     1 □ Never Married 2  Mar     3 □ Widowed 4 □ Divorce	Tied	2. Was Dec Armed Fo 1 Tes If Yes, Gi Yeer or D	2 No	U,S.		cedent of I pecify Cub	Hispanlc Origin? (Seen, Mexican, Puer Specify:	Specify Yes or No to Ricen, etc.)	0-		, White,		
Ö	2 hot	be	15. Deceder	nt's Educ	etion		18e.	Decedent's U	suel Occur	pation		16b. K	(ind of Bus	will Lo	fustry	
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21	filed within Hygiene. Wher than "	E	Unk.		Un			N/A				N/	Α			
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<u>a</u>	should be nd Mantai marked or matic eve	To E	R. B. Johnson							Caroly	n Koethe					
an	S D E I		19a. Informent's Name/Reletion	ship (Typ	e, Print)		19b.	Mailing Addr	ess (Street	t and Number or R	ural Route Numb	er, City	or Town, S	Stete, Zip	Code)	
	1 and 2 Heelth a em 27 le		Carolyn Koethe	Mot	her		2.1	16 N. H	Rose :	St. Balt:	imore, M	D 21	224			
Baltimore,	permit. Pegas 1 and Department of Heelth Important: if item 27 any Injury or other ti		20e. Method of Disposition			20b.	Plece of	Disposition (I	Verne of	oce)	Dete	20c. L	ocation - C	City or To	wn, Stete	
m	Pega ent c nt: If ry or		1 ☐ Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (5		moval from	State		Lawn (		1	7/16/97	Ном	ard (	Co	MD	
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	Dhysisian		23a. Pert1. Enter the disease, o shock, or heart feilure. Lis	only on	e ceuse on e	ach (no	in. Don	ot enter the n	loae or ayr	rig, sucit es cerdia	c or respiretory e	mest,			Intervel B Onset en	Between
	Physician /Medicai		Immediate Ceuse (Finel		,			1.1		1. 7						1
	Examiner		diseese or condition resulting In death)	Θ.	Ful	WIUDO	1+	Hepr	2710	- Fail	SHE				1 mor	146
		ē						onsequence								1
	uted d ansit	Examiner		<b>b</b> .	1-100	1+160	7 4	onsequence	fret	1000				- 1	Mar	134
ć	n en	EXa	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury			Due to	or es e c	onsequence o	); );							
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ta	ician: The certificate rector, pag		25. Was case referred to medica	i						00 Pl 10-		Yes 2	ACINO .		Yes 2	DKN0
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6	ath. r: After re fune	to	↑ Naturel 5 Pendir 2 Accident investi		(Mon	of Injury th, Day Year)		jury M	28c. Inju	rk?  Yes 2∐No			,			
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Ē	(2 H 3 6	erti	4 Homicide	IIIIeu	buildi	ng, etc. (Spec	ify)	in onout ino	, ooc		City or To				710010	
Ξ,			29a. Certifier 1 Certifyir	n Physi	cian: To the	hast of my kn	owledge	death occurr	nd at the ti	me, date end plece	a and due to the	oouso/s	) and man	nor oc et	oted	
	五年五章	edicai		Examin	er: On the bi	asis of examin ner stated.	etion end	or Investigeti	on, In my	ppinion, deeth occi	urred et the time,	date end	d place, er	nd due to	the ceuse	e(s)
1	Withm To It comp	M	290. Signature and title of Sertific		rreati		^		29c. Licens	se number		29d. Da	ite signed	(Month, L	Dey, Yeer	)
	- S - O		X1222	Į	1 On	2	+111	'	200	9754			1131			
	6		30 Name and address of account	Ann	Aplated	USIA E	21 11	7 1 4 11 4	MO.	7 404			1171	17		
			30. Name and eddress of person	Who con	A 1	e or deeth (Ite	m 239) (⁵	ype, Print)								
	Sta	to	31. Dete filed (Month, Day, Year)			egistrer's Sign	ature									
	Sta Registr		JUI 1 5 1997	4		vidson-ut		2								



State of Maryland / Department of Health and Mental Hygiene 97 2 14 19

						Cer	tifica	te of	Death		Re	g. No.	f the		
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	Exami		4e. Fecility Name (If not institution, g	tes Nurs	ing 8	Home				ltim		4c. County	of Deeth		
	Funeral Director		5. Social Security Number 6  248-18-0963  Usuel Residence of Decedent	Sex 7. A	ge (In yrs. l. 78	ast birthdey). Yrs.	Months	er 1 Year Deys	If Under 24 Hours	Min. 8.	Date of Birth (Month, Day, 1-22-	Year) 18	9. Birthple Counti	sce (State ry) SC	e or Foreign
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	o May	cto	Md	NA	Ba	ltimo	re							1 🖾 Ye	es 2 No
	death with the Maryland ma 23a or 28a-f show r.mast.be.notified.at	ral Director	10e. Street and Number		Apt.	202	10f. Z	ip Code	13		10	g. Citizen of V	Whet Country	ri A	
21215-0020	ours after alf, or its Examine	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Wes Decedent Armed Forces 1 □ Yes 2 ☑ If Yes, Give Yeer or Detes:	? INo				dispento Origi an, Mexican, Specify:	in? (Specify Puerto Rica	Yes or No- an, etc.)		e - Americe ck, White, e		
5	5 重温	Completed	15. Decedent's (Specify only highest of	Education prede completed)		16e. Deced (Give	kind of w	ork done	during most of	of working	11	6b. Kind of B	usiness/Indu	stry	
121	within ine. than h	dm	Elementery/Secondery (0-12)	College (1-4or	5+)			use retire	d)					. 7 .	bamam
	be filed tal Hygie d other event, th		10th Grade 17. Father's Name (First, Middle, La	NA st)		סמ	mes	tic	18. Mother	's Name (F	irst, Middle, Mi			эте	homes
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ž	2 should and Men is marks sumstic	F	19a. Informent's Neme/Reletionship		·	19b. Meilin	a Addre	ss (Street			oute Number,		-		1212
90532	The second secon		James Watts			1					altim				
Baltimore,	ges 1 I of He or oth		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3  4 □ Donetlon 5 □ Other (Spe		CE	ace of Dispos	sition (N	ome of other ple	ce)			Oc. Location -		m, State	
Balti	permit. Pa Departmen Important: any injury 9059.		21 Signature of Funeral Service Lic		7	22	Name	hil	ess of Facility	300					4
			23a Part1. Enter the disease, or co hock, or heart feilure. List on	mplications that cause	d the death	. Do not ente	er the mo	de of dvi	ng, such es ca	ardiac or re	spiretory erres	nue	Ba!	He Me Approxim	- Cl
	Physician /Medical Examiner		Immediate Ceuse (Finel diseese or condition resulting in deeth)	. meta									1	Intervel B Onset en	d Death
Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	an/Medical Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest	b. Mali		es e conseques es e conseque			mal	e	Huss	ion.			
	the att	Physician/	Pert II. Other significant conditions	contributing to death t	but not resu	Iting in the ur	derlying	cause gir	ven in Pert I.	12	23b. Did tob	acco uee co	ntribute to	lhe caue	e of death?
s, P.O	es that the de igned by the be detached	by Phy						_			1 🗆 Yes	2 □ No	3 ☐ Probe	ibly 4	Unknown
Division of Vital Records,	law requir has been si je 2 should	Completed								_	24a. Wes en perform		com	e eutops leble prio pletion of eath?	y findings or to f cause
a F	The la										1 ☐ Yes	2 No	10	Yes 2	No
Z:	9 10	Be	25. Wes case referred to medical examiner?	Hospital:				Ott	00F: • 4		heck only one				
on of	Service Service	tion: To	1 Yes 2 No  27. Menner of Deeth  15 Natural 5 Pending 2 1 Accident investigat	28e. Dete of Inju		28b. Time of Injury	1 3□ E	28c. Inju Wo	4 Nurs	28d	5 Resident Describe hov				
Divisi	after death Birector: d in by the	Certification:	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of in	ijury - At hor tc. (Specify	me, farm, stre					Location (Stre City or Town,		per or Rural	Route Nu	mber,
	To the Hospital or within 24 hours at To the Funeral Di completely filled in	edical	29a. Certifier 1 Certifying I (Check only one)	Phyeiclen: To the best aminer: On the basis of and manner si	of exemineti	rledge, deeth on end/or inv	occurre	d et the ti	me, dete end opinion, death	plece, end occurred e	due to the ceu of the time, dat	use(s) end me e end plece,	enner es sta end due to t	ted. the ceuse	o(s)
	To the within To the comple	Me	29b. Signeture end title of certifier	) -			2	c. Licens	se number		29	d. Date signe	d (Month, D	ey, Year)	,
	4		A mathen	W.D			l	ノは、	7716			7-14	-97		
	4		30. Neme end eddress of person whe	o completed cause of	deeth (Item 5411		2-1-11				timo			122	q,
	Sta Registi	-	31. Dete filed (Month, Day, 1997	g Anglet	Sonet	ure Mande									-1



State of Maryland / Department of Health and Mental Hygiene

21420 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Month Year WESLOCK 1997 12:10 am July /Medical 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 43 WINDWHISPER LANE ANNAPOLIS ANNE ARUNDEL If Under 1 Yaar If Under 24 Hrs.
Months Deys Hours Min. Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Aga (In yrs. lest birthday) 8. Data of Birth (Month, Day, Year) **Funeral** 1□M 2X0F 213-38-7088 Yrs Director SEPT. RUSSIA 87 10, 1909 Usual Residence of Decedant with the Meryland 10a, State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or flems 23s or 28s-f show traumstic event, the Medical Examiner must be notified at 1 Yas 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 111 HAMLET HILL ROAD #601 21210 U.S.A. Funeral filed within 72 hours aftar death 12. Was Decedant Evar in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indien, Black, White, etc. 11. Marital Stetus 1 Nevar Married 2 Married 1 ☐ Yas 2 ☐ No If Yas, Give Year or Detes: 21215-0020 1 ☐ Yes 2 ☐ No Specify. þ Specify: WHITE 3 C Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry Peges 1 and 2 should be filed within nent of Heaith and Mentel Hygiene. int: if Item 27 is merked other then? Elamantary/Secondary (0-12) College (1-4or 5+) 8 HOUSEWIFE OWN HOME Baitimore, Maryiand 17. Fether's Nema (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Surnama) Be SAMUEL PRESSMAN TOBY UNKNOWN 10 19a. Informent's Name/Ralationship (Type, Pnnt) 19b. Meiling Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Depertment of Health a Important: If Item 27 is any injury or other tra LAWRENCE F. WESLOCK / SON 43 WINDWHISPER LANE ANNAPOLIS, MD 21403 20b. Plece of Disposition (Nama of cematary, crematory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☑ Burlal 2 ☐ Crametion 3 ☐ Ramoval from State HAR ZION TIFERETH ISRAEL 7/11/97 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Sarvica Licansee 22. Name end Addrass of Facility SOL LEVINSON & BROS., INC. 8900 Reisterstown Rd Pikesville, MD 21208 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximeta Intarval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final Pulmonary 2days disease or condition resulting in deeth) Examiner Dua to (or as a consequence of): Examiner Ischemic or Attending Physician: The law requires that the death certificate be axecuted the death. burial-transit Sequantially list conditions, if any, laading to immadiate cause. Enter Undarlying Cause (Disease or Injury that initieted evants rasulting in daath) Last Dua to (or as e consequance of): and P.O. Box 68760 attending physician for use as the buria Physician/Medical Dua to (or as a consequence of) been signed by the a should be datached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. ò 24b. Ware autopsy findings eveilabla prior to complation of cause of daath? Completed 24a. Wes an autopsy performed? has 1 Yas 2 No certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was care rafarrad to medical axarmar? Be 26. Placa of Death (Check only ona) axaminar? Othar: 4☐ Nursing Home \$ Rasidance 6 ☐ Othar (Specify) Certification: To 1 ☐ tnpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? After 1 Natural 5 Panding 1 □ Yas 2 □ No 2 Accident Investigetion the Director: 6 ☐ Could not be detarmined 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) þ 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and mannar as stated. Medicai 29a. Cartifiar 2 Medicat Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signatura and titla of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Name and addrass of parson who complated cause of deeth (Itam 23a) (Type, Print) V 300,900 Annapolis Md 2140 Barbara 31. Data filed (Month, Day Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 97

					Ce	rtificate	e of	Death			Reg. No.		(toda E	1 has 1
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Examiner		4a. Fecility Nema (If not institution, giv				MEC			wn, or L	ocation of Dea		ounty of Deat		Joann
Examine	'	Stella Maris						Tow	son		В	altimo	ore	
Francis		Social Security Number 6. S	ex - 7. Ac	ga (In yrs. last	birthday)	If Under	1 Year	If Under		8. Dete of B				Steta or Forei
Funeral Director			□M 20 F	87	Yrs.	Months	Days	Hours	Min.	(Month, D	1910	Co	uintry)	
	-	Usual Residence of Decedant						<u> </u>		riay 1)	, 1710	I let.	rylar	Iu
one than "natural, or items 23s or 28s-f show the Medical Examinet must be notified at aminet must be notified at amineted by Finners i Director		10a. Stata 10b. County		10c. City, To	own or Lo	ocation							10d. Ins	ide City Limi
등급 는	0	Maryland Baltimo	re	m4 v	noni	189								Yes 2
8 8	2	10e. Street and Number	10	111	notit (	-1	0-4-				10-00-			
to Cheein and Mentel Hygiens. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examiner must be notified at To Be Completed by Finners in Director	5					10f. Zip						n of What Co	untry?	
23	20	14 Rose St.						1093				.S.A.		
E a		11. Maritel Stetus	12. Wes Decedant Armed Forces?	Evar in U,S.	13.	Wes Deced If Yes, spec	ant of H	lispenic Ori en, Mexican	gin? (Sp	ecify Yes or N Rican, atc.)	0- 14.	Race - Ame Bleck, White		en,
P. III		1 Navar Merried 2 Married	1 ☐ Yes 2 👫	No		1□ Yes 2	20	Specify:						
100	S C	3 X Widowed 4 □ Divorced	Yaar or Detes:					Opcony.			30	pecify: Wh	Lte	
ygiene. her than "naturalit, the Medical I		15. Decedent's Ed (Specify only highest gra	ducation	16	Ba. Dece	dent's Usue	Occup	alion	t of work	ina	16b. Kind	of Business/	Industry	
Department of Heelth and Mentel Hygiene. Important: if item 27 is marked other than " any injury or other trauments event, the Men once.  To Be Compile	2	Elementary/Secondery (0-12)	College (1-4or )	5+)	life.	kind of wor DO NOT us	e retired	dining mosi d)	OI WOIK	uig				
	0	12			Pre	esider	it				Weave	r Stor	ne Co	
d other		17. Fathar's Nama (First, Middle, Last)						18. Motha	r's Nam	e (First, Middle	e, Meiden Su	mama)		
arked artic ev		Charles Gill						A	The	ta Ho	ole			
THE P	-	19e. Informent's Neme/Reletionship (	Time Print)	1	Oh Mailie	na Addrese	/Straat			al Route Numi		our Chata	Zin Codel	
7 le trau		Joyce W. Clifton		1						Md. 21	-	JWII, GIGIO, 2	-ip 0000)	
Par Par	-		- daugnt					IMOUT	um,				_	
r te		20e. Method of Disposition  1 ☐ Burial 2 ☐ Cremetion 3 ☐	Removel from Stata		tery, crer	osition (Nem matory or ot	ther plea	ce)	İ	Dete	20c. Locat	tion - City or	Town, St	ete
La Cr		4 Donetion 5 Other (Specific			Cre	emator	У	July	15,1	997	Balti	more,	Md.	
any inj		21. Signeture of Funerel Service Licer	saa			2. Name en	d Addre	ss of Fecilit	У					
E & 8		I South I	10 DX		E	khard	t F	unera	1 Ch	Rd. Ow:	4 M	477	16.2	24445
	+	23a. Part1. Enter tha disease, or com	plications that caused	d the death D								TTTP,		ximata
d by the ettending physician end leteched for use as the burlet-trensit Physician/Medical Examiner	Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last	c	Due to (or es Due to (or es Due to (or es	ive e consec	Hear	ct 1	Failı	ıre					
e ette ed for	2	Pert II. Other significant conditions of	ontributing to death b	out not resulting	in the u	nderlyina ca	ause aiv	en in Pert I.		23b. Did	I tobacco us	e contribute	to the ca	use of dear
ed by the deteched										10	Yes 201	No 3∏P	robably	4□Unkne
be de de de de de														4 Unkno
ald by										24a. We	s an eutopsy	24b.	Were eut	opsy finding
pege 2 should										perf	formad?		availeble completio	n of causa
pe 2	-												of deeth?	
										10	Yes 2X	10	1 ☐ Yes	2 No
ector Beton	3	25. Wes case referred to medical examiner?	41 1 5 1				120			h (Check only				
	2	1 ☐ Yas 2 █ No	Hospitel: 1 Inpatie		Outpetier		A Oth	er X4X Nu	rsing Ho	me 5 Ras	ildenca 6	JOther (Spe	cify)	
the funeral	:	27. Menner of Deeth  1 □ Neturel 5 □ Pending	28a. Dete of Inju (Month, De	ry Year) 28t	. Time of Injury	28	Bc. Injur	y et k?		28d. Dascribe				
atio		2 Accident invastigetion				М		Yes 2 🗆	No					
Director: In by the ertifical	2	3 ☐ Suicida 6 ☐ Could not be determined	28e. Pieca of inj	ury - At home,	farm, str	eet, fectory,	, office			28f. Location		lumber or Ru	ural Route	Number,
ed in by the funer ed in by the funer Certification:		4 Homicide	building, etc	c. (Specify)						City or 10	wn, Stete)			
6 =	-	29e. Certifier 1 VCertifying Ph	ysician: To the best of	of my knowled	ne deeth	occurred e	t the tin	na data an	d place	and due to the	causo(s) an	d menner es	etatod	
pletely fi	3	(Check only 2 Madical Exam	iner: On the basis of	f exeminetion (	end/or In	vastigation,	In my o	plnion, deet	th occur	red at the tima	, date and ple	eca, end due	to the ca	use(s)
Me Me		29b. Signeture and little of conflice		0.00.		29c	Licens	e number			29d Data s	igned (Mont	h Day Y	ear)
78		1000	641	0			Liverio				7	14	17	
/_							D	15504	1		/			
		30. Neme and eddress of person who	completed cause of d	leeth (Item 23a	a) (Type,	Print)								
4		Eddie Nakhu	da, M.D.	230	0 D	ulane	ev 1	Valle	ev F	Rd Tim	onium	n, Md	210	)93
State		31. Date filed (Month, Dey, Year)	32. Ragistra	ar's Signeture	30 .		7		-					
Registrar		1111 1 5 1997	· Nav	Davidson-	Mande	مالك								
		JUL - O	0											

DHMH 16 Rev 6/95

점점하다. 이 사람들은 그는 사람 모든 것으로 나가 내 가 Trace Land Land 1971 Add 1871 Telescope 1971

3. TIME OF DEATH

9:40 P

DHMH-16 Rev 1/89

FOR STATE REGISTRAR

MARY

1. DECEDENT'S NAME (First, Middle, Last)

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THE INSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the	THE PUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be a	B.	
10	4	æ	1
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	213-26-097		1 🗆 M 2 🛣 F	6. AGE (III YIS. 16	YRS.	MONTHS	DAYS	HOURS	MIN.	7. DATE OF BIRTI	,1929	Country) Mary	ACE (State or Foreign Vland
OR	90. FACILITY NAME (If not in Carroll C	lo. Ge		pital				nins		EATH	9c. COL	arro]	тн
5	RESIDENCE OF DEC						-	Terror					
_	Maryland	Carr			10c. CITY	г, тоwn ог На		non stea	d			1	LIMITS?
ERAL	100. STREET AND NUMBER 2140 Ha	rvey	Gummel	Rd.			101	210				U.S.A	AT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 3 X Widowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2.A	RMED NO	H H	yes, sp	CENDENT O	n, Mexice	NIC ORIGIN? (Specific, Puerlo Rican, etc.)	y Yes or No-	14. RACE -	American Indian, white, atc.
9	15, DEC (Specify only	EDENT'S EDU	CATION completed)	16a. D	ECEDENT'S	USUAL OC	CUPATIO	ON		16b. KIND OF	BUSINESS/IN	DUSTRY	WILLOG
IPLETI	Elementary/Secondary (0		College (1-4 or 5+	) ,iii	ecret	e retired.)	unng mo	ist of workin	o .	Sp	ring	Grove	
COMP	17. FATHER'S NAME (First, M.	iddle, Lest)						18. MOTH	ER'S NA	ME (First, Middle, Me		-	
BE (	J. Herbe	rt Mo	rsberge							Cusack			
5	William D.		ott	19	b. MAILING 2294	ADDRESS	Street •	Ri	or Rural I	Rd. Ham	Town, State, Zi pstea	d, Md	1. 2107
	20er-METHOD OF DISPOSITI 1 ABuriel 2 Crematio 4 Donallon 5 Other	n 3 🗆 Reme	oval from Stala	20b. PLACE	ANDDATEO	FDISPOSI	ION (Na	rme of		DATE 20v	LOCATION -	City or Town	
	21. SIGNATURE OF FUNERAL		Ellard :			22. N	AME AI	D ADDRES	S OF FA	ciuty neral C	hapel	ar orn	Md. 2
	23. PART I. Enter the di	. 1				32	96	Char	cmi]	L Dr. M	anche	ster,	Md. 23
NO	iMMEDIATE CAUSE (Fin disease or condition resulting in death)  Sequentially list conditi	<b>+</b>		(OR AS A CONSE	OUENCE OF	):							Morath
ERTIFICATION	If any, leading to immed cause. Enter UNDERLY!! CAUSE (Disease or inju- that initiated events resulting in death) LAS!	flata NG ry		(OR AS A CONSE									
MEDICAL C	PART II. Other significan	LEUR	contributing to	death but not	resulting li	1 tha und	ariyinç	g cause g	lven In	PEF	S AN AUTOPSY FORMED? S 2 NO	AM CO OF	ERE AUTOPSY FINDIN AILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 PNO
CIAN:	25. WAS CASE REFERRED TO	MEDICAL					28 PI	ACE OF DE	PATAL IOL				
(A)	EXAMINER?		HOSPITAL:	ER/Outpatient 3		OTHER:				ock only one)			
PHY	27. MANNER OF DEATH  1. Natural 5   F	Pending	28a. DATE OF (Month, De	INJURY	26b. TIME	OF 2	8c. INJI WO	URY AT		6 Other (Specify) 28d. DESCRIBE HO	W INJURY OC	CURED	
ETED BY	3 Suicide 6 0	nvestigation Could not be latermined	28e. PLACE Of building,	F INJURY — At he	me, larm, at	reet, factor				26f. LOCATION (Str City or Town, S	set end Number tate)	or Rural Route	e Number,
COMPLE	29e. CERTIFIER (Check only one) 1. CERTI	FYING PHYSIC	CIAN: To the best of ex	my knowledge, da	ath occurred	at the tim	e, date nion, de	end place, eath occure	end due	to the cause(s) and time, date and place	manner ee ate	led. ne ceuse(e) an	d menner ee stated.
BE L	296. SIGNATURE AND TITLE	OF CERTIFIER	lls	MD				29c. LICE					onth, Day, Year)
	30. NAME AND ADDRESS OF HILL AM  31. DATE FILED (Month, Day, Y	TE	1	E4- M			C	ARR	OLI	- Cour	174 (	TENER	RAL HOSP

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

WALTEMEYER

2. DATE OF DEATH
MONTH
JULY -1

DAY 3

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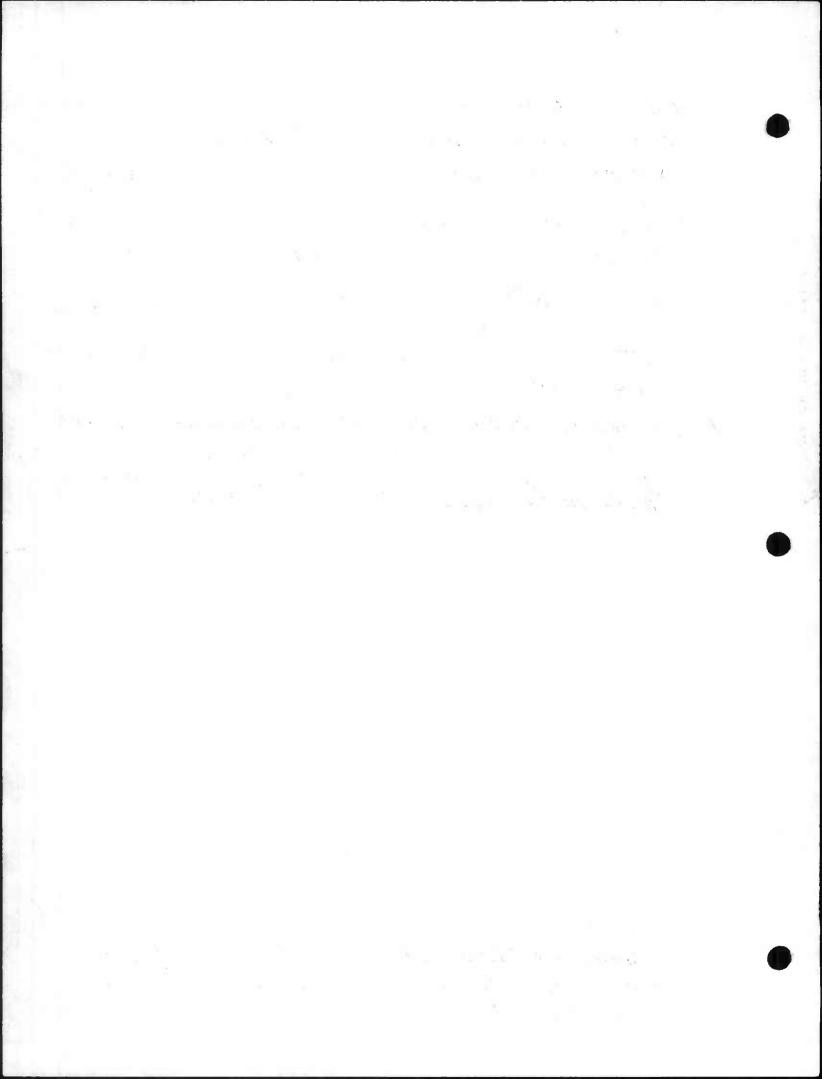
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State of Maryland / Department of Health and Mental Hygiene 97 2 142:

					Ce	rtificat	e of	Death			Reg. No.			
		1. Decedent's Neme (First, Middle, L.	1							2. Dete of D			3. Tima of Dec	eth
Physician /Medical	_	Okinge U	elliA.	ms						Month July	Dey 1 1	9 9 7	10:40	P
Examiner		4e. Fecility Name (If not institution, gi	va straat end n	um <i>ber)</i>				4b. City, Town		-		y of Death		
		VA MHCS FORT I	HOWARD	DIVIS	TON			BAI	hm	ere				
Funeral		5. Social Security Number 6.	Sax	7. Age (In yrs.		If Undar		If Under 24	Hrs.	B. Deta of Bi	irth	9_Birtho	lece (Stete or Fo	raion
Director	ŀ	254-66-2563	1 M 2□ F	53	Yrs.	Months	Days	Hours	Min.	(Month, D	ey, Year)	Coun	elece (State or Fo htry)	
	F	Usual Rasidence of Decedent										CC	0	
filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or items 23a or 28a-1 show nit, the Medical Examiner must be notified at a Completed by Funeral Director		10e. Stete, 10b. County		10c. Ci	ty, Town or Lo	ocation						1	0d. Inside City L	mits
Many to	2	Yeshad non	e	B	alten	mer.							1 Yes 2	] No
ith the Mail or 28a-f s	6	10e. Street end Number		100	,	10f. Zip					10g. Citizen of	What Cour	day?	
ours after death with the Marylan rail; or items 23a or 28a-f show Examiner must be notified at by Funeral Director		2215 ORlean	r 54.				121	13			CCS		my :	
r frems 23mm rust	5	11. Maritel Status	12. Was De Armed F	cedent Ever in U	,S. 13.	Wes Dece	dant of H	ispenic Origin en, Maxicen, I	n? (Spec	ify Yas or N	o- 14. Ra	ce - Americ		
표를 교		1 Never Merried 2 Married	12 Yas	2 No					ruerto H	ican, etc.)	Bla	ick, White,	atc.	
by Est	2	3 Widowed 4 □ Divorced	Yeer or	ive Detes:		1 ☐ Yes	No.	Specify:			Apecia	3 Ans	en lone)	
ygiene. Ne then "natural", It, tre Medical Ex-	3	15. Decedant's E	ducetion		16e. Dece	dent's Usu	el Occup	etion	V		16b. Kind of B	Jusiness/Inc	dustry	-
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s marked other than aumatic event, tre M To Be Comp	5	Elementary/Secondary (0-12)	College	(1-4or 5+)	Med	7/ (	Not	KER.			STRE	55	Dept.	
vent, n	5	17. Fether's Nema (First, Middla, Las.	t) •		1 10 10				s Name	First. Middle	, Meidan Sumar	me)		
matic even		OPINGE (N)	11im-	C						, non mount	, moratar ourna			
T T	-	CC1110 CC1	. ,					Unkn						
w 2		19a. Informent's Neme/Reletionship			19b. Maili	ng Address	s (Street	end Number	or Rurel		per, City or Town		Code) 1/2/3	
or other tr		Leonard M.	Will	s dr.	2213	OR	lean	15 St.	15	attern	er, M	-		
5		20e. Method of Disposition	To construct to		Plece of Disponentary, great	osition (Ner metory or c	me of other plea	ce)	17)	Date	20c. Location	- City or To	wn, State	,
any injury or of		1 Burial 2 Cremetion 3 Capacion 5 Other (Special Control of the Co	_Hemovel from fy)	State	nete	0		•	1	1197	Atenso	riller	med 21	25
흔	1	21 Signature of Funerel Service Lice		,		2. Name er	nd Addre	ss of Fecility	1.10	1C.Aco	Funere			
once.		2/2	4		3	das	(1)	Casall	COM	St. R	alline -	2.1	2122	>
	4	Theeself M.		esce										
		23a. Parti Enter disaesa, or con shock, or he feilure. List only	nplications that one ceuse on	caused the deat eech line.	h. Do not ent	er the mod	da of dyin	g, such es ca	ardiec or	respiratory a	arrest,		Approximate Interval Between	n
cian	1											į	Onset end Deet	h
ical	1	Immediete Cause (Finel diseesa or condition	Lu	ing Can	cer							į	1 Yr.	
niner	1	resulting in deeth)	e	Due to (d	or es e consec	uence of):						-		
je je			Me	tastas								1		
Examiner	I.	Sequentially list conditions	b. ———		or es a consec	9						1		
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				,,.						ŧ		
Sal B		Ceuse (Diseesa or Injury thet initieted events	c	D /-										
edical		resulting in death) Last		Due to (c	r as a conseq	uance or):						1		
3 2			d									1		
Physician.												1		
hed for		Pert II. Other significant conditions	contributing to	death but not res	ulting In tha u	nderlying c	ause giv	an In Part I.		23b. Did	tobacco use co	ntribute to	the cause of de	ath?
Phy Phy										1 🗆	Yes 2□ No	3 Prot	bably 4 🗆 Unk	nown
d be de														
should										24a. Wes	s an autopsy ormed?	24b. We	ere eutopsy findir ailabla prior to	ngs
page 2 should										pon	OIIIIOG !	COL	mpletion of cause deeth?	9
page 2										10	Van OÜNA			
		08 144	T								Yes 2 No	11	]Yes 2□ No	
Be		25. Wes case referred to medical exeminar?	Hospitel:				Oth		f Deeth	Check only	one)			
To al dire		1 Yes 2 No	1125	· · · · · · · · · · · · · · · · · · ·	ER/Outpetier			4 LI NUIS	-		Idence 6 Ott		y)	
ner on		27. Manner of Death 1 ☑Naturel 5 ☐ Pending	28e. Date (Moi	of Injury orth, Dey Year)	28b. Time of Injury	2	28c. Injur Wor	y et k?	28	d. Describe	how injury occur	red		
ati		2 ☐ Accident investigation				М		Yes 2□No						
ed in by the funeral		3 Sulcide 6 Could not be determined	200. FIEC	a of Injury - At he	ome, ferm, str	eet, factory	y, offica		28		(Street end Num.	ber or Rura	l Routa Number,	
ding		121101110100	Odin	ang, etc. (opeca	<b>Y</b> /					Only or 10	wn, 31010)			
		29a. Certifier 1 Certifying Pt	veiclan: To the	e best of my kno	wiedge, deeth	occurred	et the tin	ne. dete end r	olace, ar	d due to the	ceuse(s) and m	enner es si	eted	-
pletely fill edical		(Check only 2 Medical Examone)	miner: On the b	pasis of examine	tion end/or inv	vestigetion	, In my o	pinion, deeth	occurred	et the time,	date end pleca,	end due to	the cause(s)	
Med		29b. Signeture end title of certifier				290	Licens	a number			29d. Date signe	ed (Month	Dev Veer)	
6	T	A STATE OF SOUTH OF		2 .		250		10-00	0-		0/-	100	- 3), . 041/	
		Augustin	2. CM	mu	m.d.		N-1	8290	5		1/2	191		
	:	30. Name and address of person who	completed cau	solof deeth (Iten	1 23e) (Type,	Print)								
		AUGUSTIN CHYU,	MD 9	9600 No	orth F	Point	Ro	ad Fo	rt	Howar	rd, MD	2105	12	
State		31. Deta filed (Month, Day, Year)		Registrer's Signa						.10 11 01	41 (1)	THE ST. U.	F. Est.	
Registrar		JUL 1 5 1997	40	his think	· m ·									

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pe or Print in Black Indelible Ink. Assure A State of Maryland / Department of Health and I	Mental Hygiene 97	21424
Certificate of Death	Reg. No.	
		a management of

							C	Certificate o	f Death			Reg. No.		
			1. Decedent's Nam	ne (First, Middle, L	ast)						2. Dete of De Month	eth	Voor	3. Time of the
	hysicia /Medic			JOAN	WARD						0	7 Dey 12	1°9°97	1430
	xamin		4e. Fecility Neme (			ber)					cation of Death	4c. Count	y of Death	
			ST AGN	NES HOSPI	TAL				B	ALTIM	IORE		N/A	
Fu	neral		5. Social Security N		Sex 7	. Age (In yrs.		Months Dev		24 Hrs. Min.	8. Date of Birt (Month, Da	th y, Year)	9. Birthple	lece (State or Foreign
Din	ector		074-22-3		10 M 2027	68	Yrs	S.			NOV 27	1928		YORK
9 1			Usual Residence o 10a. State	10b. County		10c. Cit	hv. Town o	or Location					10	0d. Inside City Limits
ly in	and at	ò			MODE								"	1 ☐ Yes 2 No
the second	chotified at	Director	MD 10e. Street end Nu	BALTI	MORE	CA	TONSV					40- 00	140-1-0	
20 0	0 8				2012			10f. Zip Code				10g. Citizen of		Iry?
w dies	mant.	era	11. Marital Status	RNT OAK	12. Wes Deced	tent Ever in 11	10	12 Was Doosdont o	21228	ining /Con	oif. Vac or No		SA ce - America	an Indian
	iner m	Funeral		rled 2X Married	Armed Ford	ces?	,,,,	<ol> <li>Was Decadent of the second of the</li></ol>	uben, Mexice	n, Puerto	Rican, etc.)	Bla	ick, White, e	
100	XA D	by F	3 Widowed		If Yes, Give	**		1□ Yes 2☐N	lo Specify.			Specia		r m z
2 hours	Signal, Ex			15. Decedent's I			16e. De	ecedent's Usuel Occ	upetion			16b. Kind of E	WHI Business/Ind	
72 niv	100	Completed		cify only highest g	rade completed)	4m F - \	(G lif	Give kind of work dor fe. DO NOT use reti	ne during mos ired)	t of worki	ng			
d within plans.	4	E	Elementary/Seco	ondery (0-12)	College (1-	40r 5+)	H	OMEMAKER				OWN	HOME	
Hygin	1 6 5	Be C	17. Fether's Neme	(First, Middle, Las	st)				18. Moth	er's Name	(First, Middle,	Maiden Surna	me)	
should be nd Mental	tic e	To	WIL	LIAM R	OONEY				F	ELIZA	BETH	COONEY		
	umatic		19a. Informent's N	ame/Relationship	(Type, Print)		19b. M	Meiling Address (Stre	et and Numb	er or Rura	Route Number	er, City or Town	, State, Zip	Code)
of Hoalth a	er fr		CALEB H.	WARD, S	R., HUSB	AND	600	8 BURNT C	AK ROA	AD, C	ATONSVI	ILLE, M	2122	28
100	r other			Method of Disposition 20b. Place of Disposition (Name of							Dete	20c. Location	- City or Tov	wn, Stete
Pages nent of	ury or		1 ☐ Burial 2 ☐ Cremetion 3 M2Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) GATE OF HEAVEN							7	/16	HAWTH	ORNE	NV
Department monetant	any injury		21. Signature of Funeral Service Licenses 22. Name a						tress of Fecili	ty				141
991	8 8		> KE	Oles 2	Hack			STERLING						00
			23a. Pert1. Enter t	he disease, or cor	mplications that ca	used the deat	th. Do not	736 EDMON	lying, such es	cerdiac o	r respiratory e	rest, MI		Approximete
hvsi	ician		shock, or hea	art tailure. List onl	y one ceuse on ee	ch line.							i	tritervel Between Onset end Death
	dical		Immediate Ceuse disease or condition	(Final	\	. O	, , ,	_					\	(
xam	niner		resulting in deeth)	л	6	Nue to (	or es e con	nsequence of):					17	1000
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and	1 1 1 1 1	Examine	Sequentially list co	enditions,	b. C. S.	Due to (c	or es e con	nsequence of):						J. Cars
9 19 19			Sequentially list co if eny, leading to in ceuse. Enter Unde Cause (Disease or	nmediate erlying	De la	Ma	-00	31 =1	50	212			i	2)05
chusician	2.5	Medical	that initiated events	5	c. Pw			sequence of):		- ( _	)		1	)((())
certificate refine other	2 6		,		152.	(00	N - (	0-0						Das.
	lo us	Physician/			d. 5 0 0									1200
te death	8	/sic	Part II. Other elgnif	ficant conditions	contributing to dea	th but not res	ulting in th	ne underlying cause	given in Pert	i.	23b. Did	tobacco use co	ontribute to	the cause of deeth?
	detach	F B									t 🗆	Yes 2 No	3 Prob	babty 4 Unknow
vd benoi	2.8	þ												
requi	pinou	Completed										en eutopsy rmed?	eve	ere eutopsy findings eilable prior to
	1 to	현											of d	npletion of cause deeth?
e te	800	00									101	Yes 2 No	1 🗆	Yes 2□ No
ician: The lay cartificate has	900	Be	25. Was case refer examiner?	red to medical					26. Plece	e of Death	(Check only o	one)		
Physicia This cart		0	1 ☐ Yes 2	No	Hospital: 1 ☐ In	patient 2	ER/Outpa	atient 3 DOA	Other: 4 🗆 Nu	arsing Hor	ne 5 🗆 Resid	dence 6 □Ot	her (Specify	)
hart har	9	ü	27. Manner of Deat  Naturel	th 5 ☐ Pending	28a. Date of (Month)	Injury Dey Year)	28b. Tim tnju		jury et lork?	2	28d. Describe I	now injury occu	rred	
eath.	100	cat	2 Accident	Investigation	ho -				☐ Yes 2☐	No				
or All after d Direct	A D	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not l determined	280. Place o	t Injury - At he	ome, farm,	, street, factory, offic	8	2	28f. Location (S City or Tox		ber or Rural	Route Number,
Mospital 4 hours Funeral	to's	edical	29a. Certifier (Check only	Certifying P	hysicien: To the b miner: On the bas	est of my kno is of examine	wledge, de	eath occurred et the r investigation, in my	time, dete en	d plece, e	end due to the	ceuse(s) end m	enner es ste	eted. the ceuse(s)
9 5 6		Med	one)		end manne	er stated.								
TOT	1		29b. Signature and	title of certifier				29c. Lice	nse number	^ .		29d. Dete sign		
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14	1	(	Name end eddr	ess of person who	completed cause	of death (Iten	n 23e) (Ty	pe, Print)		_		Tuly		1
Sup	/		Jeann	ine So.	indess		Ca	ton Au	ZNU	C 1	Salt	non	-21	229
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Re	egistra	ar .	JUL 15	133/	0		16							

WRC 97-3699-510 BASIL WAG

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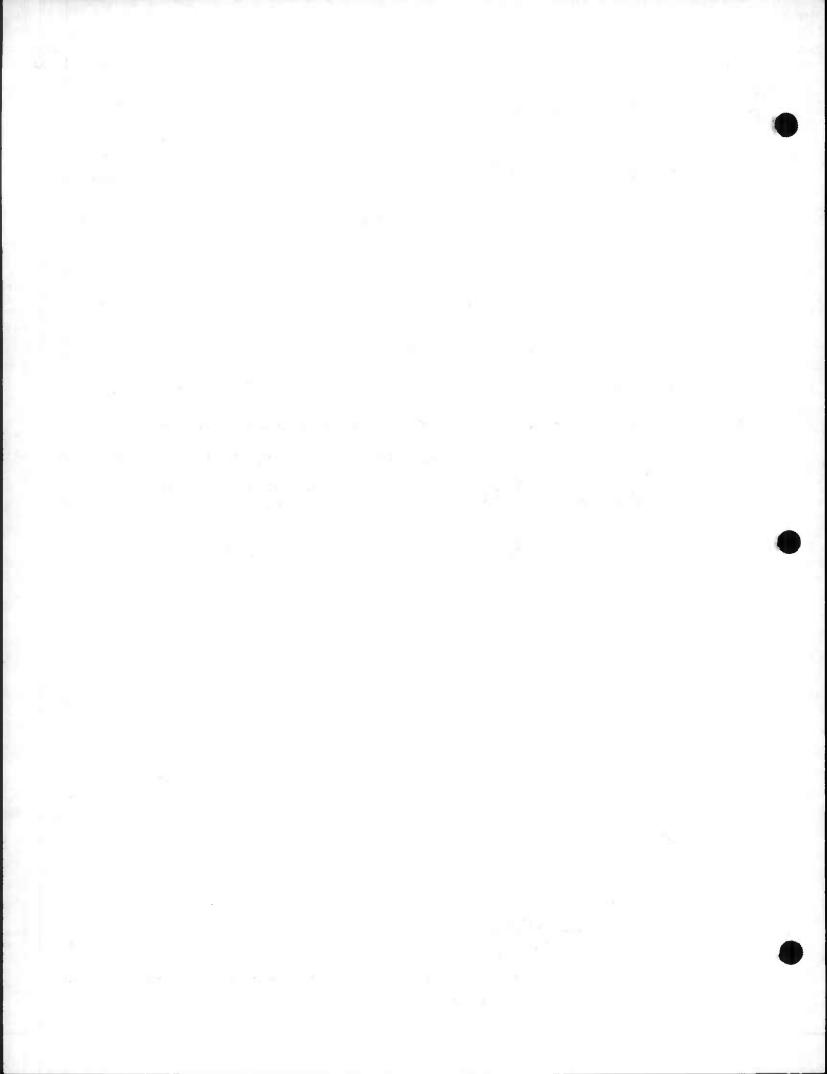
State of Maryland / Department of Health and Mental Hygiene 07

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GN:	ER JR.				C	ertificate o	of Death		Reg. No.	1	21423
	Discorte		1. Decedent's Name (First, Middle, Las	st)				2. Dete of D		Year	3. Time of Deeth
	Physic /Medi		Basil Wagner					JULY		1997	3:50 PM
	Exami		4a. Fecility Neme (If not institution, give	e street end number)			4b. City, Town, or	Location of Dea	ath 4c. Count	y of Deeth	
			5422 YORK RD.				BALTI		NA		-
	Funeral		5. Sociel Security Number 6. S	ex 7. Age (In yrs		Months Day	ear   ff Under 24 Hr ys Hours Mir	8. Date of B (Month, L	irth Day, Yeer)	9. Birthr	plece (Stete or Foreigntry)
	Director		219-18-8768 Superior Street St	78	Yrs.				, 1919	Ma	ryland
	fand		10a. State 10b. County	10c. C	ity, Town or	Location					10d. Inside City Limits
	tha Marylan r 28a-f show	ō	MD NA	1	Balti	more					Ne Yes 2□Ne
	r 28e	Director	10e. Street end Number			10f. Zip Cod	е		10g. Citizen of	Whet Cou	ntry?
	23% or		5610 York Rd.			212	212		USA		
	72 hours after death with the Maryland nature!', or frems 23d or 28a-f show sidel Examiner must be notified at	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J,S. 1	3. Was Decedent of	of Hispenic Origin? ( uben, Mexican, Pue	Specify Yes or N	lo- 14. Rai		cen Indien,
0	aftar or its		1 Never Married 2 Married	1 Tyes 2 No		1 Tes, specify C		no nicen, etc.)		ck, White,	etc.
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21215-0020	natu	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. De (G	cedent's Usual Oci ive kind of work do	cupation ne during most of wo ired)	orking	16b. Kind of B	usiness/In	dustry
2	within ane.	du	Elementary/Secondery (0-12)	College (1-4or 5+)		sician	urea)		Mus		
9		ပ္ပို	17. Fether's Neme (First, Middle, Last)		Mus	sician	18 Mother's Na	me (First Middle	le, Maiden Sumer		
an	8 E 0 8	o Be	Basil Wagner					-11.	ttison		Ъ
Maryland	nd 2 should be filed the and Mental Hyg It is marked other traumatic event,	To	19a. Informent's Name/Relationship (	Type. Print)	19b. Ma	ailing Address (Stre	eet end Number or F				
S	O1 00 07 00		Charles Webb Wa				lian Lan				
ē,	Haalth Ham 27 I		20a. Method of Disposition	20b	Place of Dis	sposition (Neme of tremetory or other p		Date	20c. Locetion		
Ę	Page ant o nt: If		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specific				Cremator	v 7-12	Balti	mor	e, MD
Baltimore,	mit.		21. Signature of Funeral Service Licen			22. Neme end Ad	dress of Fecility				
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			23a. Past. Enter the disease, or comp shock, or heart failure. List only	plications that caused the dee	eth. Do not	enter the mode of o	York Rd	ec or respiretory	timore,	, MD	21212 Approximete
9	Physician		shock, or heart failure. List only	one ceuse on each line.						i	Intervel Between Onset end Death
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н	Examiner		resulting in deeth)			sequence of):	, , , , , , ,				
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80	os exe cian a surial		Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury	0							
68760,	cate be a physician s the buria	Medical	thet initiated events resulting in death) Lest	Due to (c	or es e cons	sequence of):		-			
-	는 말이		L L	d							
Box	file and for	Physician/									
P.O.	9 6 2	ysi	Pert II. Other significent conditione co	ontributing to death but not res	sulting in the	undertying cause	given In Pert I.				o the cause of death
	es that the igned by be detact	by Pt						10	Yes 2 No	3 🗌 Pro	bably 45 Unknow
of Vital Records,	- # 5							24e. We	s en eutopsy	24b. W	ere eutopsy findings
8	w requir s been s should	jete						per	formed?	CC	veilable prior to empletion of cause deeth?
Re	The law ate has page 2	Completed						1	Yes 2₽No		☐Yes 2☐No
ta	delan: Th certificate rector, pay	Be C	25. Was case referred to medical				26 Place of Dr	eath (Check only			
≥	E = 0	To B	examiner?	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpat	tient 3 DOA	0		sidence 6 10th	ner (Sneci	AT COPNE
0	arthis seral d		27. Menner of Death	28e. Date of Injury (Month, Dey Year)	28b. Time		njury et Vork?	_	how injury occu		SCENE
Ö	tending i leath. Ior: After the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injur		Yes 2 No				
Division	Affe or de recto by th	tifle	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm,	street, factory, offic	CO CO	28f. Location	(Street end Num.	ber or Run	al Route Number,
	pital or A purs attar eral Direc filled in b	Certification:		building, etc. (Open	·· <b>y</b> /				o, 0.0.0)		
	the Hospital or Atten hin 24 hours after deat the Funeral Director: npletely filled in by the	edicai	(Check only 21 Medical Exam	yelclen: To the best of my kno lner: On the besis of exemine	owledge, de	ath occurred et the	time, dete end plac	e, end due to the	e cause(s) end m	enner es s	iteted.
1	within 24 ho To the Function	Med	one)	end manner stated.							
1	6258	-	29b. Signature end title of cortifier.	11/1		290. Lice	ense number	,	29d. Date signe		
,	/			/ 76		Sec. at the	O.C.M.E	. ·	JULY	05,	1997
/			30. Name end eddress of person who of				eet, Bal	timore	, Marv	land	21201
			100010	-ww					1		

State Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Pearl E. Wiles 1997 July 14, 3:30 am 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1615 Four George Court Dunda1k Baltimore Co. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept 16, 1942 Maryland 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 3 F 54 Yrs 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Co. Dundalk XXYes 2 No 10f. Zip Code 10g. Citizen of What Country? Four George Court 21222 U.S.A 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 N Married 1 ☐ Yes XX No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Ivy Hall Nursing College (1-4or 5+) Nurses Aide Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George K. Burris Marthe Martin 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) John E. Wiles (Husband) Four George Court, Dundalk, Md 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Green Mount Cemetery 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 7/17/97 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Balitmore, Maryland 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse of each line. Approximate Intervel Between Onset and Deeth Cachexia Ischemic Bowel) therosclerosis )iabetes Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Artherosclerotic Coronary Artery Pisease 1 Yes 2 No 3 Probably 4 Unknown Chronic Renal Failure - Dialysis Dependent 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

Pages 1 end 2 should be filed within 72 hours effer death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show rai', or items 23a or 28a-f shorest and Examples in new total at Baltimore, Maryland 21215-0020 7 Is marked other than "nature traumatic event, the Medical : If item 27 or other t **Physician** 

**Physician** 

/Medical

Examiner

**Funeral** 

Director

5. Social Security Number

218-36-4227

10a. State

Directo

Funeral

þ

Completed

Be

Maryland

Usual Residence of Decedent

1615

Elementary/Secondary (0-12)

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last

1 ☐ Yes 2 No

27. Menner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

The lew requires that the death certificate be executed ettending physician end for use as the burial-transit

/Medical

Examiner

Examiner

Physician/Medical

Completed by

Be

2

Certification:

Medical

sion of Vital Records, P.O. Box 68760, Itending Physician: Diractor To the Pu

> State Registrar

31. Date filed (Month, Day, Year) JUL 15 1997

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)



and the second s

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year OAM Mary A. Whitehead NIL 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of De BALTIMORE 111 Taunton Avenue Catonsville If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months 1 □ M 2 T F 215-12-5340 May 27 1922 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore Catonsville 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 Taunton Avenue 21228 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Yes 2 TNo Specify Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Insurance Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Arthur Aston Bertha Hutchinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Ann W. Kraus/Daughter 3216-A Normandy Woods Dr. Ellicott City, MD21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery 7/14/97 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD MacNabo Funeral Home, P.A. 21. Signature of Funeral Service Licenses McDonald McDonald Dawn F. 301 Frederick Rd. Baltimore, MD 21228 Dawn F. McDona I.d

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Type 2 No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

MD

Director

Funeral

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Completed

Be

2

**Funeral** 

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic avent, its Marsical Examination to any injury or other traumatic avent, its Marsical Examination.

Baltimore, Maryland 21215-0020

with the Maryland

the burial-transi and attending physician certificate be ass esn ò detached 8 certificate Physician: this

fter t hdigg lon

after death Director Aft

To the Hospital within 24 hours a To the Furreral D

Medical

Records, P.O. Box 68760,

of Vital

Examiner Physician/Medical by Completed Be 2 Certification:

25. Was case referred to medicel examiner?
1 Yes 2 No

27. Menner of Death 1 Natural 5 Pending investigation

2 Accident 3 ☐ Suicide 4 Homicide

29a. Certifie

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

28c. Injury at Work?

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1 Yes

Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, State)

Recepcial CATONSVILLE, md.

childing Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as steted.

colical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

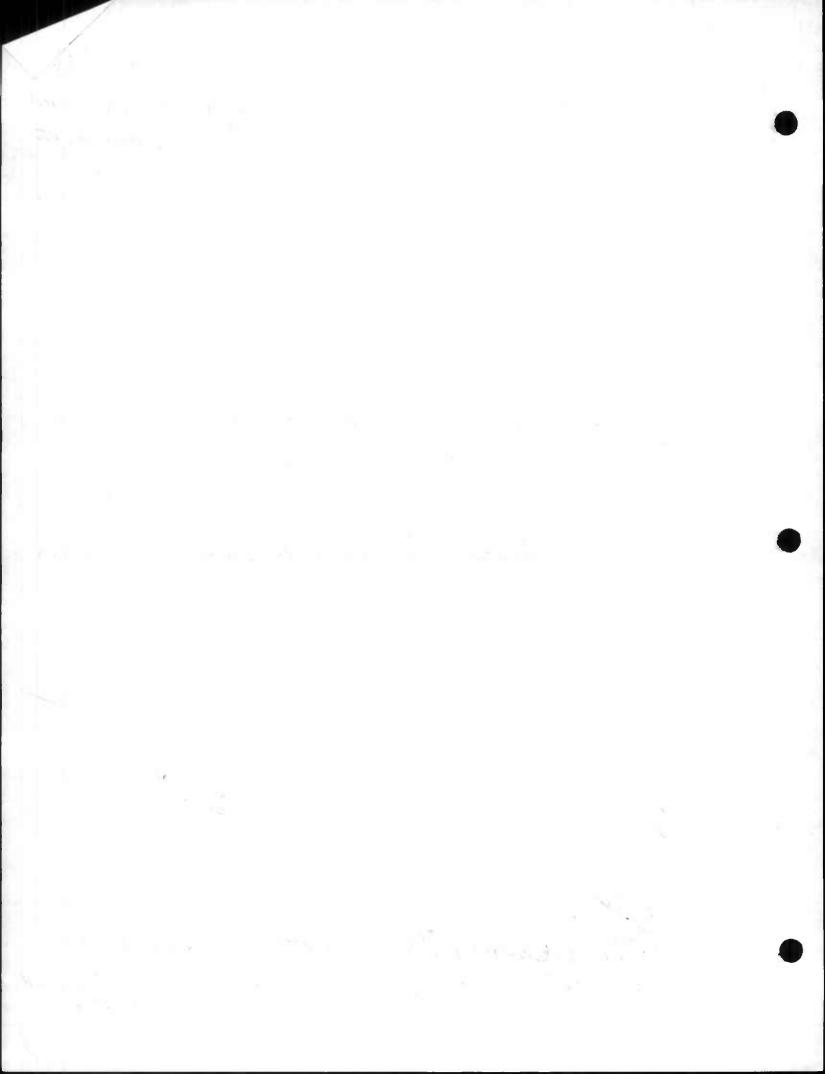
29d. Date signed (Month, Day, Year)

30. Name end add who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 5 199

32. Be

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Deeth Day **Physician** Month July 2,1997 Vincent WELSH 8:16 P.M. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Franklin Square Hospital Center Rosedale Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) 1√2 M 2 □ F Deys Hours 218-24-8528 Yrs. March 10, 1930 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location Baltimore County 10b. County 10d. Inside City Limits Maryland Baltimore Director 1 ☐ Yes 2 🕱 No 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 9921 Richlyn Drive 21128 U.S.A. by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Manufacturing 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Carl Vernon Welsh Thelma Lucinda Matthews 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Lois Welsh/wife 9921 Richlyn Drive, Perry Hall, Maryland 21128 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S <sup>22</sup> Name end Address of Fecility State Anatomy Board, 655 W. Baltimore Street Wade Director 23a. Panl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, anock, or heart feiture. List only one cause on each line. ade Immediate Cause (Final disease or condition resulting to death) <sub>e.</sub> Sepsis 2 weeks Due to (or es e consequence of): Examiner b Colon cancer with extensive mets 3 years Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that hitiated events resulting in death) Lest Due to (or es a consequence of): Physician/Medicai Due to (or as e consequence of): Pert II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Acute tubular necrosis 1 Yes 2 No 3 Probably 4 Unknown by Completed 24a. Wes en eutopsy 24b. Were eutopsy findings eveitable prior to completion of cause of deeth? performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No. Be 25. Was case referred to medicel exeminer? 26. Piece of Death (Check only one) Hospital: 1₺ Inpatient 2☐ ER/Outpetient 3☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28e. Dete of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 X Naturat 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 1X Certifying Phyelcian: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) Pine MD R D 2323 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 Franklin Square Dr. Baltimore, Maryland 21237

State Registrar

**Funeral** 

Director

permit. Peges 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercises.

**Physician** /Medical

Examiner

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The law requires that the de

or Attending Physician:

Division of Vital Records, P.O.

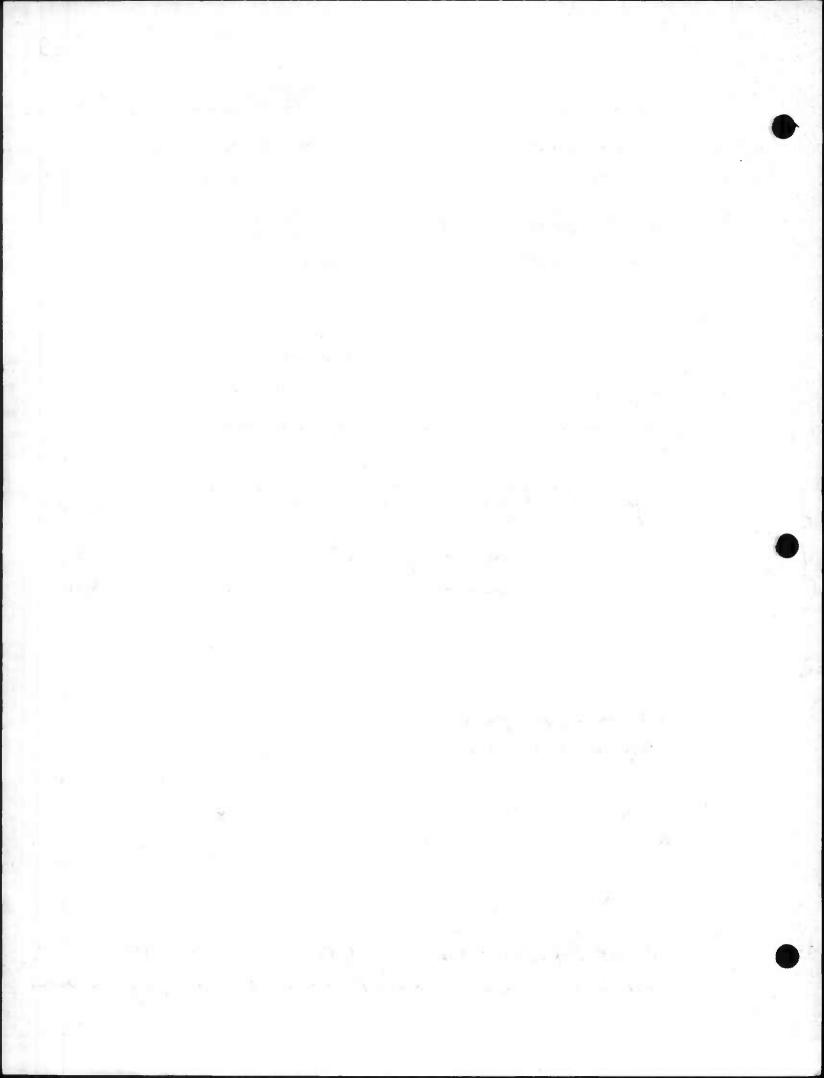
31. Dete filed (Month, Day, Year) JML 1 5 1997

Dr. Kristen Pena

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Month 28, Alma E. Anderson June 1997 6:20 PM /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Deeth 428 Northwest Drive Silver Spring ar If Under 24 Hrs. 8. Dat s Hours Min. Montgomery 5. Social Security Number If Under 1 Year 6 Sex 7. Age (In vrs. lest birthday) 8. Date of Birth (Month, Dev. Yeer) **Funeral**  Birthplace (State or Foreign Country) 1□ M 2□ F Months Deys Yrs. Director 579-16-0274 76 Sep. 7.1920 Washington, D.C. Usuel Residence of Deceden tha Maryland 10a Slete 10h County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 □ No Maryland | Montgomery Rockville 10e, Street end Number 10f. Zip Code 10g. Citizen of What Country? death with Funeral 5 Pebble Ridge Court 20854 U.S.A. 12. Was Decedenl Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ∑No
If Yes, Give
Year or Dates: 11. Maritai Slalus 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiane. Important: If feen 27 is merked other than "natural", or fler any Injury or other traumatic event 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify. 3 Widowed 4 □ Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) 12 Personnel Administrator PEPCO 17. Father's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul S. Hanson Annadelle E. Link 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Martha Christine Anderson 5 Pebble Ridge Court Rockville, Maryland 20854 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stale 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 7/2/97 Suitland, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Pern University Bivd., W., Silv ship is the disease, or complications fine caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, ship is not peen failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physiclan** /Medical Immediate Ceuse (Finel Aspiration precon disease or condition resulting in death) **Examiner** Examiner Demantia, Chin burial-transit Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lasl and Due lo (or es e consequence of): physician as the burial-Box 68760 Physician/Medical Due to (or es e consequence of): Part It. Other significant conditione contributing to death but not resulting in the underlying ceuse given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Chronic Lymphocytic Centernia Records, þ 24b. Were eutopsy findings eveilable prior to completion of ceuse of death? Completed 24e. Wes en eutopsy performed? Deep vonon thumbusis 1 Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attending Physician:
 24 hours aftar daath.
 Funeral Director: After this certifica 25. Was cese referred to medical examiner? Be 26. Ptece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpalient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 28 No funaral 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of Certification: 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Phyeician: To the best of my knowledge, death occurred et the time, dete end place, and due to the ceuse(s) end manner es steted.

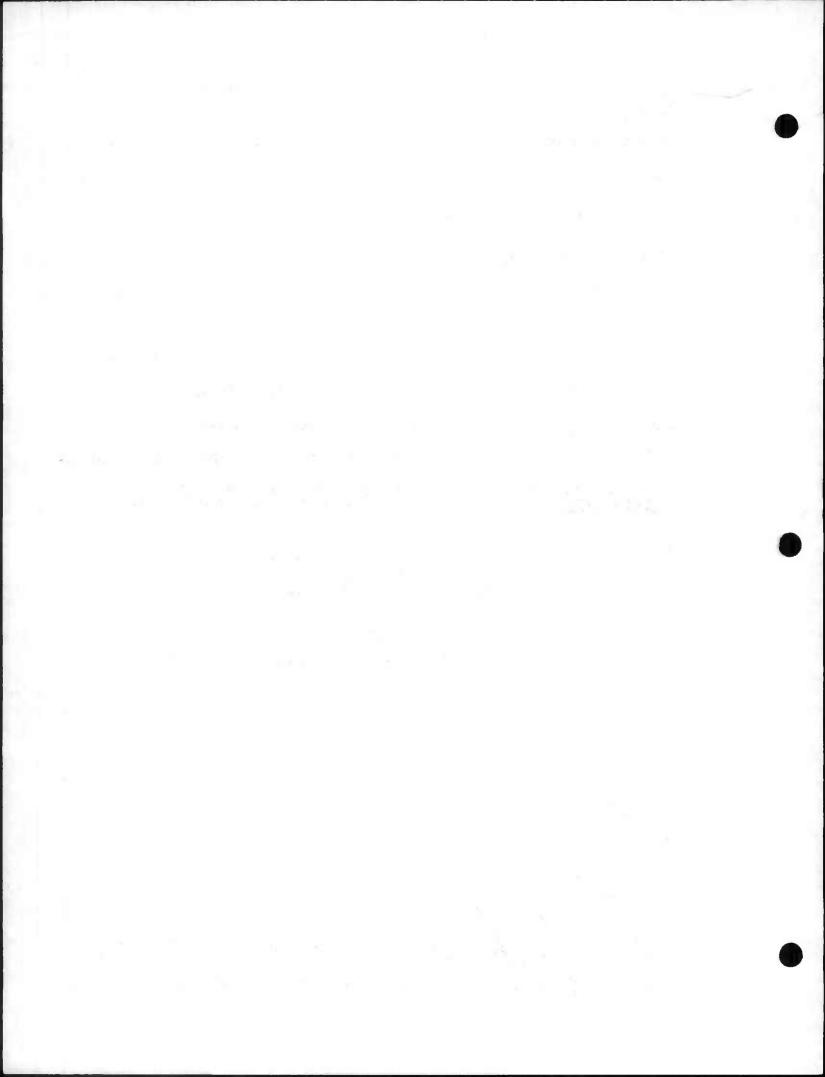
[2 Medical Examiner: On the basis of examinetion end/or investigation, In my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) and menner stated. 29a. Certifier To th. within 2. (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Dale signed (Month, Dey, Year) D47215 30. Name end eddress of person who completed cause of deeth (ttem 23a) (Type, Print) (Robert Musselm, Ma) Silver Spring, MD 20901 Lockwood Dr. # 200 1997 Registre spane we down State

Registrar



State of Maryland / Department of Health and Mental Hygiene 97 2 1 4 3 0

						(	Certi	ficate	of	Death			Reg. N	No.			
			1. Decedent's Neme (First, Midd	dle, Last)							-1	2. Date of De				3. Time of Deat	th
	Physic		Ect-11-	77								Month		)ey	Yeer	6 - 40DM	
	/Medi		Estelle 4a. Fecility Neme (If not institution	Akst	umborl					4h City To	um or Lo	June cation of Deat	-			6:40PM	
A.	Exami	ner			umber)									c. County			
_			Suburban Hosp								esda				jomer	•	
L	Funeral Director		5. Sociel Security Number 074–40–8602 Usual Residence of Decedent	6. Sex 1 ☐ M <b>2</b> ☐ F	7. Age (In 87	yrs. lest birth Y		If Under 1 Jonths	Deys	If Under Hours	Min.	8. Date of Bir (Month, Da ay 18,	th y, Yee 19	10		laca (Stete or Fore try) Russia	aign
	Aaryland I show nd at	or	10a. Stete 10b. Count	gomery	100	. City, Town								A. 800	10	0d. Inside City Lin	
	Pe N	Director		gomery		NOCKV	1116										140
	23a or		10e. Street end Number 1801 E. Jeff	erson St.				10f. Zip C					10g. C		Vhet Coun	try?	
Maryland 21215-0020	72 hours after death with the Maryland "natural", or items 23s or 28s-f show idical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Merried 2 ☑ Mai 3 ☐ Widowed 4 ☐ Divorcei	Armed F	2. ZNo ive	in U,S.	If Y	s Deceder es, specif	y Cub	en, Mexicar	gin? (Spe n, Puerto I	cify Yes or No Rican, etc.)	<del> -</del>	Blac	a - America k, White, o	etc.	
20	in 72 ho "natur Redical	Completed		nt's Education		16e. l	Deceden	t's Usual	Occup	pation during mos	t of model		16b.	Kind of Bu	siness/ind	lustry	
21	within ene. than "r	pie	Elementery/Secondary (0-12)		(1-4or 5+)		life. DO	NOT use	retire	dunng mos d)	t or workir	ng					
7	N SE SE	DO.	12		( , , , , , , , , , , , , , , , , , , ,		Home	make	r					Own	Home		
P	I Hygi other rent, 1	Be	17. Father's Name (First, Middle	, Last)						18. Mothe	r's Name	(First, Middle	Maide	en Sumem	e)		
ā	Mental Mental urked o	To B	Morris Wexle	r						Fre	ida	Kren	t-z1	0			
Ž	M bd M	-	19a. Informent's Name/Relation			19h	Meiling	Address (	Street			I Route Numb			State Zin	Code	
×	0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1																
	S 1 an 1 Heat tem 2 other		George Akst 20a. Method of Disposition	/ Son	20	b. Place of I				d Ave.	A	nnanda					
Baltimore,	artment of a crtant: If its injury or of		1 Buriel 2 □ Cremetion 4 □ Donation 5 □ Other (5	, cremet	ory or oth	er pla		rden	Dete s 7/2/			City or To	urch, Va.				
Ball	Depart Import any in		21. Signature of Funeral Service	Coposo						ess of Facility		1 Dire	cti	on e. Má	20	852	
			23a. Pert1. Enter the disease,	complications thet	caused the	death. Do no								C/ 110	. 20	Approximete	
	Physician /Medical Examiner	9.	shock, or heert failure. Lis Immediate Ceuse (Final disease or condition resulting in deeth)		Bow Bow	oe/	onseque	er f	01	rakec						Intervel Between Onset end Deeth	
ox 68760,	eath certificate be executed attending physician and for use as the bunal-transit	v/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest	d	Car	co (or es e co co (or es e co chas	onseque	nce of):	H	y		ncino	in,	5			
Bo	death e atter	ciar					_										
P.0	hat the d ad by the detached	/ Physician	Part II. Other significant conditi	one contributing to	death but not	resulting in	the unde	erlying ceu	use gir	ven in Pert I				2 □ No	atribute to 3 ☐ Prob	the cause of dea eably 4 12 Unkn	
Records	aw requiras is been sign 2 should be	Completed by								_		24a. Wes	en eut		cor	pre eutopsy finding silable prior to appletion of cause deeth?	
	E age	Ö										10	Yes	20 No	1□	Yes 2 No	
Vital	ysician: The s cartificate director, pag	Be (	25. Was case referred to medical exeminer?	al						26. Plece	of Deeth	(Check only o	ne)				
2	Solo	0	exeminer/ 1 ☐ Yes 2 ☑ No	Hospital:	Unpatient	2 ER/Outp	petient	3□ DOA	Ott	ner: 4 🗆 Nu	rsing Hon	ne 5 Resi	dence	6 □Oth	er (Specify	<i>'</i> )	
of		L :	27. Manner of Death	28e. Dete	of Injury	28b. Ti	me of		c. Inju			8d. Describe					
0	th. After funer	엹	1 ☐Naturel 5 ☐ Pending 2 ☐ Accident investi	ng (Moi igation	nth, Dey Yea	r) Inj	jury	м		rk? Yes 2∐l	No						
Division	or Attanding after daath. Director: Afte d in by the fune	Certification:	3 Suicide 6 Could determ	not be 28e. Plac	e of Injury - i	At home, fam ecify)	m, street	, factory,	office		2	8f. Location ( City or To	Street e vn, Sta	end Numb ite)	er or Rura	l Route Number,	
	Hospita 24 hours Funeral	edicai C	29a. Certifier 1. Certifyli (Check only one) 2 Medical	ng Physicien: To the Examiner: On the band me	e best of my pasis of exam	knowledge, nination end/	death oc	curred et tigetion, in	the ti	me, date en opinion, dea	d pleca, a	and due to the	cause(	(s) end me nd placa, e	nner es st end due to	eted. the cause(s)	
	To the within To the comple	Me	290. Signatu Ave title of certifie	-	//			29c. l	Licens	se number			29d. D	ate signed	(Month, L	Dev. Yearl	
)	8		> Man	Dry 1		MIL	)	111	Λ.	700	88		4	2/1	100		
	~~		30. Name and address of person	// //	se of deeth (	Item 23a) (T	ype, Prir	()	/	A.	0 "	2.11		1	2	20817	
	Sta	te	31. Date filed (Month, July 17 bas	13 1997 <sup>82.1</sup>	Registrati's S	ignature	NOC!	cied	98	עויוק	1	se in	900	4 /	10.	x081)	



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9.7

				State of Ivial			of Death		Reg. No.	1 4	1431		
	Physic	ion	1. Decedent's Name (First, Middle, Last)	_				2. Date of De		Yeer	3. Time of Death		
-0	/Medi		Shirley T.	Austin				June 2			9:30 A. M.		
	Examir	ner	4e. Fecility Name (If not institution, give s					r Location of Deet					
			1102 Hunters Mil				Fort Was	hington	Prince		0		
	<ul><li>Funeral Director</li></ul>		5. Social Security Numbar 6. Sex 00314-5147		7. Aga (In yrs. last birthday) 7 Yrs.  If Undar 1 Yrs.  Months D			8. Data of Bir Malyonin Da	9. Birthplace (Stata or Foreign Country) New Hampshire				
	death with the Maryland rms 23a or 28a-f show	Funeral Director	10a. State 10b. County	10	c. City, Town o	Location				10	d. Insida City Limits		
			Maryland Prince G	eorge's	Fort	Washingt	con				1 ☐ Yes 2 ☐ No		
			10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country								y?		
			1102 Hunters Mill	Avenue	Avenue 2				U.S.A.				
21215-0020	after or its	by Fune	11. Maritel Status  1 □ Never Merried 2 □ Married  3 ☒ Widowed 4 □ Divorced	Wes Decedent Eve Armed Forces?     □ Yes 2 ☑ No If Yes, Give Year or Dates:	r in U,S.	3. Was Deceder If Yes, specify 1 ☐ Yes 2 ☑	nt of Hispanic Orlgin? (Cuban, Mexican, Pue No Specify:	Specify Yes or No orto Ricen, etc.)		ca - America ck, White, et y.Black	ic.		
5-0	Pin Pin	To Be Completed by	15. Decedent's Educ (Specify only highest grada	ition 16e.		ie. Decedent's Usuel Occupetion (Give kind of work done during most of work life. DO NOT use retired)		orking	16b. Kind of B	Business/Industry			
21			Elementary/Secondary (0-12)	College (1-4or 5+)	lif	DO NOT use	retired)						
	led w hygier her th			4	M	anager			Dry Cleani		ing		
Maryland	permit. Peges 1 end 2 should be filed withir Department of Health and Mental Hygiene. Important: If Itam 27 is merked other than any injury or other traumatic event, The Mance.		17. Fether's Name (First, Middla, Last)					ame (First, Middla,		-,			
			Frederick B. Tayl		401 14		Helen		Langf				
			19e. Informent's Neme/Relationship (Type Pamela L. Beverly/	Daughter	220	6 Browns	Street and Number or F s Lane, Ft						
Baltimore,	permit. Peges 1 Department of H Important: If Ital any Injury or otl		20e. Method of Disposition 1 ☐ Burial 2 DiCremetion 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, o	sposition (Name tramatory or othe litan Ci	of orplace) rematory	Date 6/27/97	Alexand		n, State Virginia		
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licenses  **Aulas**  22. Name end Address of Fecility  George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745										
4			23a. Pert1. Enter the please, or complice shock, or heart to tre. List only one	ations that caused the	death. Do not	anter the moda o	f dying, such as cardia	ac or raspiretory e	rrest,		Approximete nterval Between		
	Physician /Medical Examiner	Je.	Immediate Ceuse (Final disease or condition resulting in death)  Due to (or es e consequence of):  Con Sestwe Leart failure										
Box 68760,	The law requires that the death certificeta be asscuted ate has been signed by the ettending physician and page 2 should be detached for use as the bunel-transit	n/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted avants rasulting in deeth) Last	Dúe	to (or as a cons	sequence of):	of Jan	luce					
	death e ette ed for	icla	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.						23b. Did tobacco use contribute to the cause of death?				
P.O.	that the death cer led by the ettendir detached for use	y Physician/N	The state of the s						1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown				
Records,	e law requiras that has been signed t ge 2 should be det	Completed by							en eutopsy med?	eveil	e eutopsy findings eble prior to pletion of cause eeth?		
		Con						101	res 200	10	Yes 2□ No		
	ysician: The is certificate director, pag	Be	25. Was case referred to medical exeminer?					eth (Check only o	ne)				
of	hya his	ဥ	1 163 2 140		2 ER/Outpat			loma 5 Residence 6 □Othar (Specify)					
_	To the Hospital or Attending P. within 24 hours efter deeth. To the Funeral Director: After the completely filled in by the funeral completely filled in com	Medical Certification:	27. Manner of Déeth  1 Aletural 5 Panding 2 Accident investigation	28e. Dete of Injury (Month, Day Year)  28b. Time of Injury  28c. Injury et Work?  1 □ Yes 2 □ No			28d. Dascribe I	28d. Dascribe how Injury occurred					
Division			3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	8e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)			281. Location (Street and Number or Rural Route Number, City or Town, State)					
			29b. Signatura and title of certifiar	10			cansa number		29d. Dete signer	d (Month, Da	ıy, Year)		
	(		Dubnk	Though	rell)	7	130296		6-	26	-4/		
(	8/		30. Name end eddress of person who com DEBORAH M	pleted cause of deeth		e, Print)	)30296 5100 Au	th way	Suitl	and	MO		
W.	Sta Registra		31. Dete filed (Month, Day, Year)  JUN 3 0 1997	32 Registrar's		A				4			

	State of Mary		epartificat			and iv	rental m	Reg. No.	, ,	21432		
1. Decedent's Name (First, Middle, I Dianne Eliz	Last)	ord					2. Dete of D Month		Year	3. Time of Death		
					T		June		997	2:PM		
4e. Fecility Name (If not institution, g		311		4			Sprine		y of Deeth			
579-58-5017 1 M 2 F 51 Yrs. Months Deys H						Min.	Pring 8. Date of 8 (Month, D	irth ay, <i>Year)</i> 301946	9. Birth Cou Was	nery place (State or Foreigntry) h. DC		
10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits												
	omery	21116	er spr	ing						XXXYes 2□N		
10e. Street end Number 603 Sligo Ave		10f. Zip Code 20910				10g. Citizen of What Co United			ntry? States			
11. Maritel Stetus	Armed Forces?	12. Was Decedent Ever in U,S. Armed Forces?  17. Yes, specify Ci			f Hispanic Origin? (Specify Yes or Nuben, Mexican, Puerto Rican, etc.)			o- 14. Race - Americ Black, White,				
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 2 No If Yes, Give Yeer or Dates:	If Yes, Give 1 ☐ Yes 2 ☐ No				Specify:				Specify: Black		
15. Decadent's (Specify only highest g	Education trade completed)	eation 16e. Decedent's Usuel Occupation (Give kind of work done during most of we life. DO NOT use retired)				of work	orking 16b. Kind of Busines			s/Industry		
Elementary/Secondary (0-12)	College (1-4or 5+)	College (1-4or 5+)				Depe of Hame						
17. Fether's Name (First, Middle, Las	2 years						Services			ces		
Chester Ambr					Bea	atr:	ice Sc	o, Maiden Suma Cott Co	oke			
19a. Informent's Name/Relationship	(Type, Print)	19b. N	lailing Address	(Street &	nd Numbe	r or Rur	al Route Numb	ber, City or Town	, State, Zij	Code)		
Eric Ashford 20a. Method of Disposition	. 2	20b. Place of Disposition (Name of			r Rd T-1 Gait			ersbur 20c. Location				
Burial 2 Cremation 3 4 Donetion 5 Other (Spec		Hemovel from Stete				7	/7/97 Landove		ver.	er. MD		
21. Signature of Funeral Bervice Ucensee 22. Name and Address of Facility Latney's Funeral Home, Inc. 3831 Georgia Ave, NW Wash, DC 20011												
23a. Perl1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.  Immediate Ceuse (Final disease or condition resulting in death)  a. Acute Myocardial Infarction									Intervel Between Onset end Death			
Due to (or es e consequence of):										Years		
Sequentially list conditions, if eny, leading to Immediate  Hypertension  Due to (or es e consequence of):										rears		
cause. Enter Underlying Cause (Diseese or injury	0								i			
thet initiated events resulting in deeth) Lest	Due	Due to (or es e consequenca of):										
d												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i.								23b. Did tobecco use contribute to the cause of de 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unke				
							performed? evelle comp			ere eutopsy finding elleble prior to mpletion of cause deeth?		
							1 Yes 2 tNo			1 ☐ Yes 2√☐ No		
25. Wes case referred to medical examiner?					26. Plece	of Deeth	(Check only			25		
examiner/ ★★Yes 2□ No	Hospital: 1 Inpatient	2 ER/Outpe	tient 3 DO	A Othe				idence 6 Ott	ner (Specif	y)		
7. Menner of Deeth 1   Naturel 5 □ Pending 2 □ Accident Investigation						28d. Describe how injury occurred						
3 Suicide 6 Could not 4 Homicide determined	28e. Placa of Injury -	28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier 1 ☐ Certifying P (Check only one) 1 ☐ Certifying P	hysiclen: To the best of my miner: On the basis of exar and manner stated.	knowledge, de ninetion end/or	eeth occurred er Investigetion,	et the time in my op	e, dete end nion, deeth	l pleca, a	and due to the ed et the time,	ceuse(s) end m date end place,	enner es s end due to	tated. the ceuse(s)		
9b. Signeture end title of certifier			29c					29d. Date signe	1 14 12 - 144			

State Registrar

Physici /Medi Examir

¿Funeral Director

permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental hygiene. Important: If Item 27 is marked other than "naturel", or items 23e or 28a-f show any Injury or other treumetic event, the Medical Examines man be notified at

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours effer death.

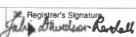
To the Funeral Director: After this certificate has been signed by the ettending physician and bompletely filled in by the funeral director, page 2 should be deteched for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

31. Dete filed (Month, Day, Year)

JUL 14. 1997



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 2 1433

						Certificate	of Death		Reg. No.		
	Brown to 1		1. Decedent's Name (First, Middle, La	ist)		19.54		2. Dete of D			Time of Death
	Physici /Medic		JOCHEN	I R. BE	ERGT			JUNI	= 16, 1	1997	4:30 PM
	Examir		4a. Facility Name (If not institution, giv	The second second				n, or Location of Dea			100-101
		И		RANDYWIN	IE RO,	4D	BRANC	YWINE		E GEO	rges
	Funeral Director		5. Social Security Number 6. \$ 574 18 9 26 4	Sex 7. Age	(In yrs. lest bi	rthday) If Undar 1 Y Yrs. Months D	ear If Undar 2 ays Hours	Min. 8. Date of E (Month, I Feb	10, 193	9. Birthplace Country) 8 Gern	(State or Foreign
	aryland show	_	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Location					Insida City Limits
	the Mi	Director	Maryland Prince	e George	s Br	andywine	do		10g. Citizen of V		1 □ Yes 2 □ No
	h with		13525 Brandyw:	ine Road			0613		United		
	deet	Funeral	11. Mantal Status	12. Was Decedent E Armed Forces?	ver in U,S.	13. Was Decedent	of Hispanic Orig	in? (Specify Yes or N Puarto Rican, etc.)		ca - Americen In	ndian,
21215-0020	72 hours efter deeth with the Maryland natural; or itams 23s or 28s-f show often Examiner must be notified at	by	XXNevar Married 2☐ Married 3☐ Widowed 4☐ Divorced	1 Yas 2 X N If Yes, Give Year or Dates:	lo	1 □ Yes 2 <b>3</b>		ruano nican, etc.)	Specify	ck, White, atc. <sup>y:</sup> White	e
15-0	n 72 hours "natural", Bolical Exz	Completed	15. Decedent's Ed (Specify only highest gra		16a	Decedent's Usual O (Giva kind of work d life. DO NOT use n	ccupation one during most	of working	16b. Kind of B	usiness/Industr	У
12	withir	Idm	Elementery/Secondery (0-12)	College (1-4or 5-		drews Go			Che	f	
	Hygi thar int,		1.2 17. Fathar's Name (First, Middla, Last)	2	AII	drews GO	1	's Nama (First, Midd			
Maryland	d la b	To Be	Atto Bergt				100000000000000000000000000000000000000		NKNOWN)	,	
ary	P E E	-	19a. informant's Name/Relationship (	Type, Print)	191	. Mailing Address (Si	raet end Number	or Rurel Route Num	ber, City or Town,	, Stete, Zip Cod	de)
	Haalth e tam 27 le		Walter Dorsey		1	3525 Bra	ndywine	e Road,	Brandyw	ine,MI	D 20613
Baltimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cem e te	f Disposition (Neme or ry, crematory or other	plece)	Date		- City or Town, S	
ţ	semit. Pag Sepertment mportant: if iny injury o		4 □ Donation 5 □ Other (Specifi		Lee	Cremator	y June	17, 199	7 Clint	on, Mai	ryland
Bal	permit. F Depertmo Importan any injur		21. Signature of Sunaral Service Library	Pel		Old Ale	xandria	Lee Fune a Ferry	Rd, Cli	ie, inc	MD 2073
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that causad one cause on each lin	the death. Do	not anter tha moda of	dylng, such as c	ardiac or raspiratory	arrast,	Inte	proximata ervei Between
V	Physician				)		9				set and Death
1	/Medical Examiner		Immadiata Causa (Final disease or condition resulting in death)	. HYPERTER	VSIVE,	arteriosci	POTIC	CARPIOVAS	SCULAR P	18EASE	
		-	,		Due to (or as a	consequence of):				1	
	be executed sicien end buriel-transit	Examiner	Sequentially list conditions	b	Due to (or as a	consequenca of):					
, 00	death certificete be executed e ettending physicien end ed for usa as the buriel-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury								
68760,	icete b physic s the b	Wedical	that initiated events resulting in daath) Last	С	Dua to (or as a	consequence of):					
	certifice ding pl		L.	d							
Вох	eath ce ettendii i for usa	Physician/	Death On a death of the					l in pi			
0	thet tha de led by the e detached t	hysi	Pert II. Other significant conditions of	ontributing to death bu	t not resulting I	n the underlying ceus	e given in Pert I.		d tobacco uae co ∐Yes 2□ No		• .
S, P	ras thet signed b	by P							J Yes Z□ NO	3 Probably	y 45 Onknown
ord	-= " 0							24a. Wa	is an autopsy		autopsy findings bie prior to
ecc	2 S	Completed							10111001		etion of ceuse
R	0 - 0	COL						10	Yes 2 No	1 🗆 Ye	s 2 No
/ita	ilcian: The certificate rector, peg	Be (	25. Was cese referred to medical examiner?				26. Place	of Death (Check only	one)		
5	Physician: this certific ral director,	9	1 Yes 2 No	Hospitai: 1 ☐ Inpatier	nt 2 ER/O			sing Home 5 Re	sidence 6 □Oth	er (Specify)	
Division of Vital Records,	tending Physician: leath. tor: After this certific the funeral director,	ion	27. Manner of Death  1 Natural 5 □ Pending	28a. Dete of Injur (Month, Day		Time of 28c.	Injury at Work?		e how injury occur	red	
isi	Attending or death.  Botor: After by the fune	ficat	2 Accident investigation 3 Sulcide 6 Could not be	e Ogo Disea of Isin	ny - At home fa	irm, street, fectory, of	1 Yes 2 N		(Street end Num!	her or Rural Ro	ute Number
<u>S</u>	effer Olra d in b	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	ini, street, lectory, or	100		own, Stete)	707 07 11010111101	210 77411207,
	To the Hospital or Attenwithin 24 hours effer deat To the Funaral Director: completely filled in by the	edical C		yaician: To the best or niner: On the basis of and manner stat	examination an						
	To the within 2 To the complete	₩ M	29b. Signature and title of certifier	100		29c. Li	cense number		29d. Date signe	ed (Month, Dey,	Year)
			Mund	12001	IN D	ME D	3395	4	JULY 2	1997	
			30. Name and address of person who	completed ceuse of de	ath (Item 23a)	(Type, Print)		-	JULY 2	1	
			MARIO F. GOLVE	JRM) 3	00 1 40	SPITAL DRI	KE, CH	Warry, M	MARYLAN	0 207	85
	Sta Registr		31. Date filad (Month, Dey, Year)  JUL 0 3 1	32. Ragietra	r's Signature	(Type, Print) SPITAL DRI Rardall	1	/ 1			
	riegisti	ar .	JULUJI	331 7000	- 00 100 m 001						

State of Maryland / Department of Health and Mental Hygiene 97

21434

	Item	1:5	per FH G-750 8/19/97 dh			Certifica	ate of		R	eg. No.	1 4	1434				
г	Dhuaisi	-	1. Decedent's Name (First, Middle, Last)						2. Dete of Dear Month	th Dey	Yeer	3. Time of Death	1			
	Physici /Medi		THOMAS BYRNE	BAKER					June	30, 19	997	3:15 PM				
	Examir		4a. Fecility Neme (If not institution, give :	street and number)				4b. City, Town, or	Location of Death	4c. County	of Deeth		-			
			440 Doris Circle					Aberdeer	1	Har	ford					
	Funeral Director		5. Sociel Security Number 6. Sex	IM 2□ F	yrs. last birt	hdey) If Und Month	der 1 Year s Days		8. Dete of Birth	Year)	9. Birthpie Countr	ece (State or Fore y) rginia	ign			
	and **		10a. Stete 10b. County	10	c. City, Town	or Location					100	d. Inside City Limi	its			
	within 72 hours after deeth with the Meryland tions. Than "natural", or items 23a or 28e-f show the Medical Examiner must be notified at	5	Maryland Harford			erdeen					100	ty Yes 2 □ N				
	Ne N	Directo	2	4	- ALA											
	£ 8 8	ā	10e. Street end Number			10f. 2	Zip Code		1	0g. Citizen of V	Whet Countr	y?				
	eth v	rai	440 Doris Circle					001		US						
	er de	Funeral		12. Wes Decedent Ever Armed Forces?	r in U,S.	13. Wes Dec	cedent of F secify Cub	Hispenic Origin? (S an, Mexican, Puer	specify Yes or No- to Rican, etc.)		e - America k, White, et					
20	or P		1 ☐ Never Married 2 🏖 Married	1 XYes 2 ☐ No If Yes, Give				Specify:		Specify						
8	uraf,	d by	3 Widowed 4 Divorced	Year or Dates: 19						100	WILL					
21215-0020	72 Tark	Completed	15. Decedent's Educ (Specify only highest grede	cation co <i>mpleted)</i>	16e.	Decedent's Us (Give kind of v	work done	petion during most of wo d)	rking	16b. Kind of Bu	usiness/Indu	stry				
12	within one. than be Mex	ig.	Elementary/Secondery (0-12)	College (1-4or 5+)												
7	京芸書名	S		5 +	Ec	ducatio	n Spe	ecialist		U.S. C		ment				
Ë	D T D D A	Be B	17. Fether's Neme (First, Middle, Last)						me (First, Middle, I							
충	2 should and Men is marks sumstic	2	Royal Frank Baker	<u> </u>				verna	a Evelyn	Muger	1					
Maryland	四 年 整 等		19e. Informent's Neme/Relationship (Ty)			-			rel Route Number	-		(ode)				
	f Health Hem 27 other tr		Elsie M. Baker - W					cie, Abei	rdeen, Mo	. 2100	) T					
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ R		20b. Piece of cemetery	Disposition (A , cremetory of	leme of r other pla	ca)	Dete	20c. Location -	City or Tow	n, Stete				
Ě	Pages nent of int: If its iry or o	-	4 Donetion 5 Other (Specify)		R.A. Fe	erris &	Com	pany	7-2-97	W. Ches	ster.	Pa.				
att	Department of my injury or answer.		21. Signature of Funeral Service License	IN.A. ICITIS & Company / 2 3/ W. Chester/ 14.												
m	STEE		► 010W. X IV	N'ama	. )											
		Н	23a, Paul Enter the distance, or compli	cations that caused the	death Don	131/	COKE:	sbury Rd.	Abingo	on, MD	2100	Approximate				
	Discontinuo	23a. Part. Enter the dishase, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.														
	Physician /Medical		Immediate Ceuse (Final								i	Onset end Death				
1	Examiner		disease or condition resulting in death)	DEHYDRA	TION							3 WEEKS	2			
		-				onsequenca o					1	3 WEEKS				
	led nsit	Examiner	_ b	METASTATIC	5A51	ille c	ARCI	NOMA				? 1/2 HON	H			
_	wecu end el-tra	хаг	Sequentially list conditions, if eny, leading to immediate	Due	to (or es e c	onsequenca o	f):				1					
68760,	The lew requires that the deeth certificate be executed ate has been signed by the ettending physician end page 2 should be deteched for use es the bunet-transit		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events								i					
87	cate phys	Physician/Medical	resulting in deeth) Lest	Due	to (or es e co	onsequence of	f):									
	entific ling p	Me									į					
Вох	eeth cert ettendin	lan									1					
	t the der by the e	sic	Part II. Other significant conditions con-	tributing to death but no	ot resulting in	the underlying	g cause giv	ven In Pert I.	23b. Did to	bacco use co	ntribute to t	the cause of deat	th?			
P.0	at the	Phy							1 DXY	es 2 No	3 Proba	ably 4 Unkno	own			
	es tha igned be del	by														
of Vital Records,	v require been si should	P							24a. Wes e	n eutopsy		e eutopsy finding	s			
Š	s been 2 shoul	Completed							,		com	pletion of cause eeth?				
æ	The lew sate hes page 2	E							1 □ Ye	s 20 No	10	Yes 2□ No				
ta		Be C	25. Wes case referred to medical					26 Place of De	eth (Check only on	- /			-			
5	60	0 8	exeminer?	ospital:	2 ER/Out	petient 3□ t	Oth		lome 5 Reside		or (Conside)					
o	Phys r this erai d		27. Manner of Death	28a. Dete of Injury	28b. Ti		28c. Inju	ry et	28d. Describe ho							
o	ding th.	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	<i>ar)</i> In	jury M	Wo	rk? ∣Yes 2 □ No								
Division	f or Attending efter death. Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Pleca of Injury -	At home, far	m. street, facto	ory, office		28f. Location (St	reet end Numb	er or Rural	Route Number.				
5	or lor l	erti	4 Homicide	building, etc. (S	pecify)		,		City or Town	n, State)						
	pital ours erai fillec		29a. Certifier 1 Certifying Phys	Iclen: To the best of my	knowledge	death coourse	d at the tir	me date and place	and due to the or	nueo(e) and ma	nnor oe eta	tod				
	To the Hospital or Attending within 24 hours effer death.  To the Funeral Director: After completely filled in by the fune	edicai	(Check only one)	er: On the basis of exa	mination end	or investigetion	on, in my o	ppinion, death occu	irred at the time, d	ate end place,	end due to t	he cause(s)				
	the the mpk	Me	29b. Signature end title of certifier	one mainer stored.		2	9c. Licens	se number	2	9d. Date signe	d (Month D	ev. Yeer)				
	F 3 F 8		1	W.	MO			7390		11/	01/94	1				
	12		Men 13 )	- 0								F				
2	15		30. Name end eddress of person who con	mpleted cause of deeth	(Item 23e) (1	Type, Print)	rul -	15.650	600 N. de	1500 35	_					
0	/		IVAN BORRELLO	JOHN'S HI	ol.kin?	ONCOLO	~ / 0	ENIEIC	600 14.	310 31						
	Sta	te	31. Dete filed (Month, Day, Year)	is is	s illafill	delle										

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Date of Deeth 3. Time of Deeth Month Day **Physician** Yee ANNA VIRGINIA BECKMAN 28, 1997 JUNE 6:30 AM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner KEISER PERSONAL CARE HOME OAKLAND GARRETT Hours Min. 8. Date of Birth (Month, pay, JUNE 15, 5. Social Security Number If Under 1 Year 7. Age (In vrs. lest birthday) 9. Birthplece (Stete or Foreign **Funeral** Year) 1907 WEST VIRGINIA 1□M 2 F Months Days 234-70-1637 90 Yrs. Director Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours eftar death with the Maryland Department of Haalth and Mental Hygiene. Important: If tem 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD GARRETT DEER PARK **Funeral Director** 1 ☐ Yes 2 N No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1065 FRICKS CROSSING ROAD 21550 USA 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: WHITE Completed by 3 X Widowed 4 Divorcad 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working iife. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 17. Fether's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be **HERVEY** FRANCIS **EVANS** CARRIE WINTERS ပ 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) CYNTHIA SIMPSON - GRANDDAUGHTER 1065 FRICKS CROSSING ROAD DEER PARK, MD 21550 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 6/30/97 EGLON CEMETERY EGLON, WV 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signa In Funeral Servica Licenses 22. Name end Address of Facility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fellure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel myocardial infarction hours diseese or condition resulting in death) Examiner Due to (or as e consequence of) Examiner the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting In deeth) Lest Due to (or es e consequence of): nding physiclen Physician/Medical Due to (or as e consequence of): use es Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 2 No 3 Probably 4 Unknown Asthma, Hypertension, Atrial Fibrillation, dementia þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? pege 2 should Completed 24e. Wes en eutopsy performed? After this certificata has 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Persona Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 are 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) Medical Certification: 28b. Time of 5 Pending investigation Home Natural 1 Yes 2 No 2 Accident

Hospital or Attending Physician: The law requiras that the death certificate be axecuted Division of Vital Records, P.O. Box 68760. death. efter death in by the within 24 hours e completaly P.

29b. Signiflure at

6 Could not be

Cartifying Physicien: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. edical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated.

D26650

29c. License number 29d. Dete signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

**9**6/30/97

30. Neme end address of person no completed cause of deeth (Item 23e) (Type, Print)

PO Box 486 Margaret A. Kaiser MD Oakland MD 21550

31. Dete filed (Month, Day, Year) State JUL

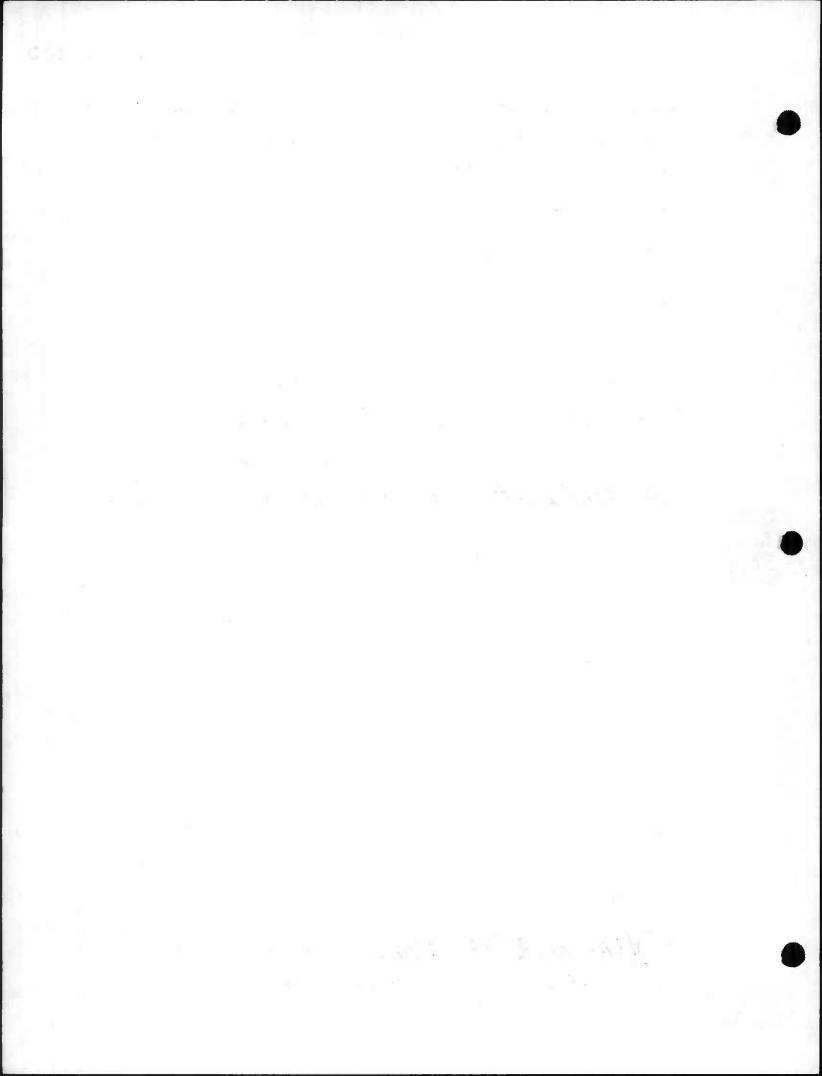
3 Suicide

29e. Certifier

4 Homicide

32. Registrer's Signature

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene

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- Contract of the Contract of			V

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev Vee **Physician** ROY RAYMOND BOHR June 19:35pm 27, 1997 /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Yeer) 6. Sex **Funeral** Months Deys Hours 1√2 M 2□ F 78 Yrs. Director 217-03-2585 April 7,1919 Maryland Usuel Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked othar than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Examiner nwat be notified at Md. Montgomery Gaithersburg Director 1 X Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 20877 United States 507A South Frederick Ave #5 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours aftar al Hygiene. other than "natural", or ite 1♥ Yes 2 No 1941— If Yes, Give Year or Detes: 1942 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No þ Specify: White 3 ☐ Widowed 4 ☐ Divorcad 1942 Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Painter Residential permit. Pages 1 and 2 should be file Depertment of Health end Mental Hy, important: if item 27 is marked oths any injury or other traumatic event, once. 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be James Bohr Pearl Jones 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 507A S. Frederick Ave. #5 Gaithersburg, Md. 20877 Virginia Bohr 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Ju1y 1997 Arlington National Cem. Arlington, Va. 22. Name end Address of Fecility DeVol Funeral Home 21. Signature of Funerel Service Lical 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Ceuse (Finel diseese or condition resulting in death) /Medical е. Нурожіа Examiner Due to (or es e consequence of): Examiner 2 Days Resperatory Failure burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of) end 2 Years Emphysema Box 68760. physician that the daath certificeta be Physician/Medical the Due to (or es e consequenca of): Nicotine Abuse Many Years attanding esn nse Division of Vital Records, P.O. the Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? signed by N☐ Yee 2□ No 3 Probably 4 Unknown Pneumonia ģ 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed peen Wieght Loss The law has paga 2 Alcohol Abuse 1 Yes 2 1-No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifics completally filled in by the funeral director, 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) and menner stated. 29a. Certifier Medical (Check only one) 29b. Signature end title of certifi 29c. License number 29d. Date signed (Month, Dey, Year) 6+ une, Um 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) RASHAID BAGHAI-NAINI 344 University Blvd. West Silver Spring, Md. 20901

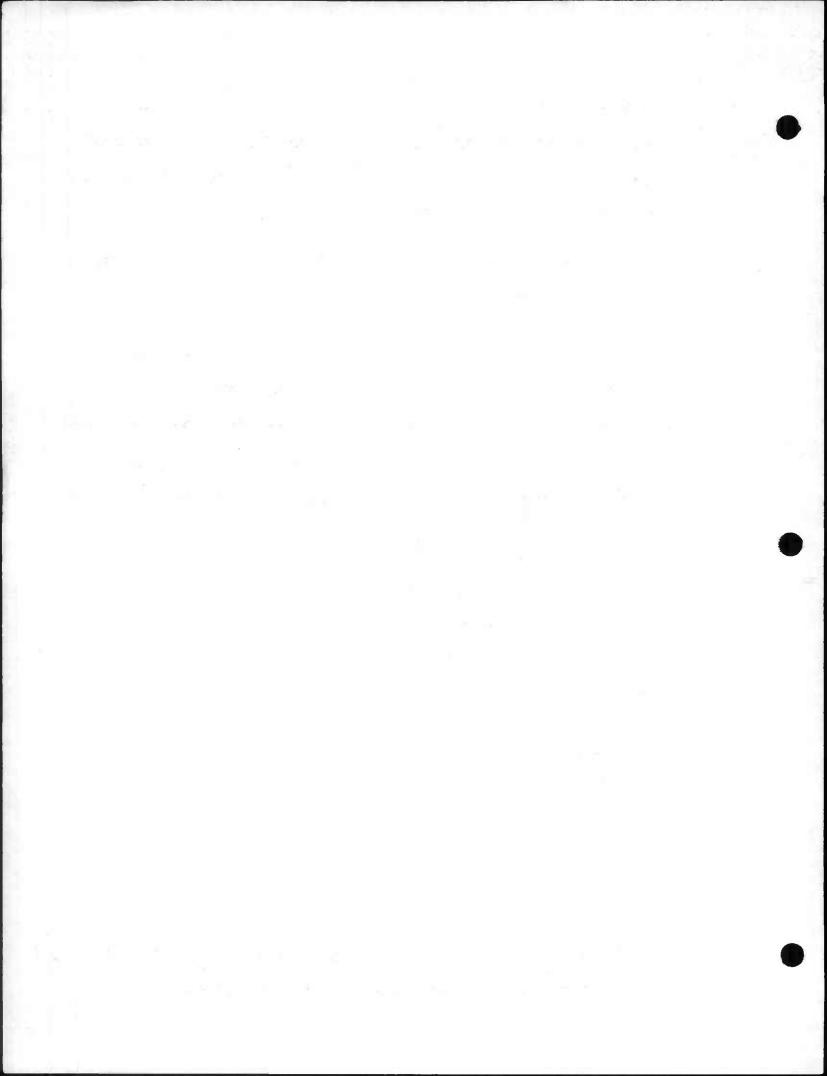
32. Registrar's Signature

wha Davidson

-Aandell

DHMH 16 Rev 6/95

State

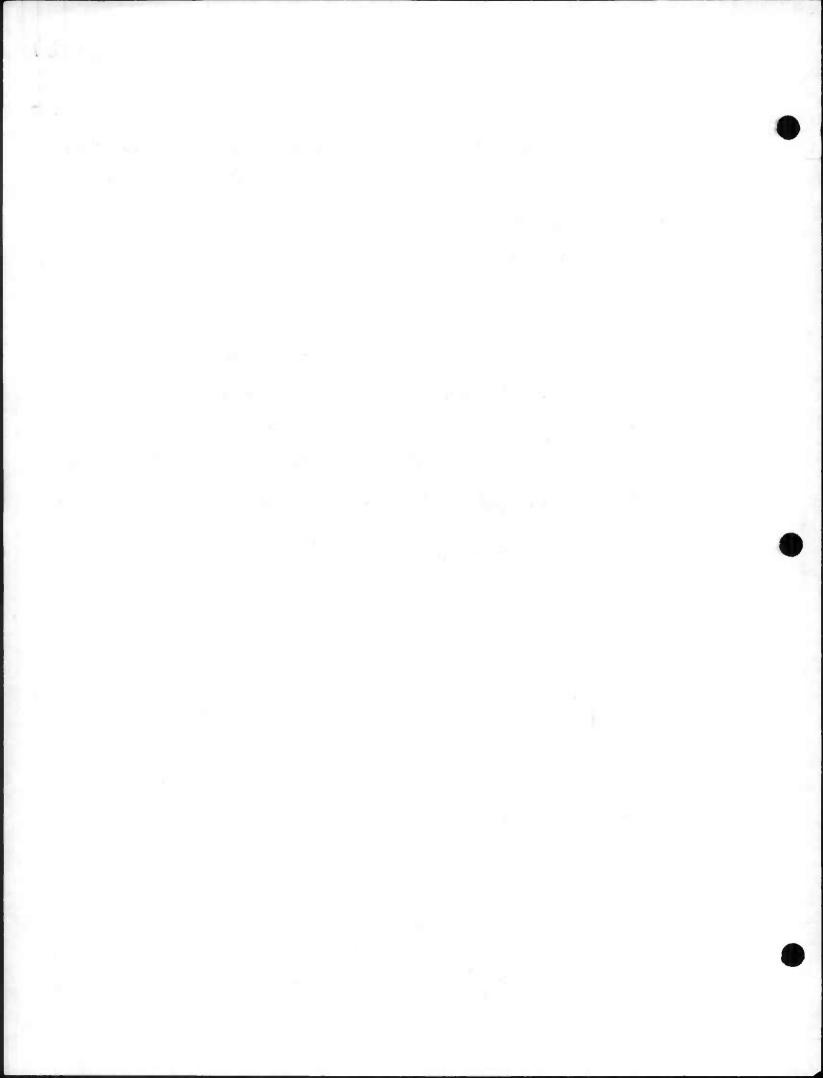


State of Maryland / Department of Health and Mental Hygiene

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Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yeer **Physician** EUGENE 27, 1997 JUNE BORLAND 5:51 AM /Medical 4a. Fecility Neme (If not institution, giva street end number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** HOLY CROSS HOSPITAL SILVER
If Under 1 Year If Under 24 Hrs. SPRING MONTGOMERY Birthplace (Stete or Foreign Country) 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Day, Yeer) **Funeral** Months Deys Hours 15₹M 2□ F Yrs Director 578-26-2820 71 WASH. D.C. FEB. 19, 1926 Usual Rasidanca of Decadent the Maryland 10e, State 10b. County 10c. City, Town or Location 10d. Insida City Limits "natural", or items 23a or 28e-f show 1 ☐ Yes 2 ☐ No Director MONTGOMERY SILVER SPRING 10e Street and Number 10f. Zip Coda 10g, Citizen of Whet Country? with 808 PHILADELPHIA AVE. 20910 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours efter deeth 1 Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, the Medical Examples research Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedenf of Hispenic Origin? (Spacify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, Whife, etc. TOYes 2 ☐ No If Yes, Give Yeer or Detes: 1 ☐ Naver Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced WWII Completed 16e. Dacedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry RESEARCH AND Elamantary/Secondary (0-12) College (1-4or 5+) DRAFTSMAN AND ILLUSTRATOR DESIGN 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maldan Sumeme) Be WILLIAM JAMES BORLAND JANE CONOVER 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Code) JULIA A. BORLAND/WIFE SAME AS ITEM #10 20b. Plece of Disposition (Name of cemetery, crametory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CHAMBERS CREMATORY 6/29/97 RIVERDALE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licent 22. Name end Address of Fecility SILVER SPRING, MD. HOMES, P.A. M0091 CHAMBERS FUNERAL 20910 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respirefory errest, shock, or heert failure. List only one cause on each line. Approximate Intarvel Batween **Physician** /Medical Immediata Cause (Final disease or condition resulting in daeth) Examiner Examiner or Attending Physician: The lew requires that the death certificate be executed buriel-transit Sequentially list conditions, if any, laading to immediata cause. Entar Undarlying Ceusa (Diseese or injury thet initiated events resulting in deeth) Lest P.O. Box 68760. Physician/Medical the Due to (or as e consequence of) esn signed by the a Part If. Other eignificent conditions contributing to death but not resulting Inhtha junderlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Nos 2□ No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings eveilable prior to Completed 24a. Was en autopsy completion of cause of death? cate hes l 1 ☐ Yes 2 ☐ No certificate Division of Vital funeral director. Be 25. Was case referred to medical examiner? 26. Placa of Daath (Chack only one) Hospital: 1 Inpatient 2 NO No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 ER/Outpetient 3 DOA After this 27. Manner of Daath 28b Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturel 2 Accidant 5 Panding invastigation s efter deeth. 1 ☐ Yes 2 ☐ No 6 Could not be dataminad 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicida within 24 hours e Hospital Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

| Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. 29a. Cartifier Medical To the 29b. Signalule and titleto 29d. Date signed (Month, Day, 29c. Licanse number 45 30. Name end eddress of person who completed causa of áth (Item 23a) (Type, Print) 10301 D. MAHONKY CARROLL M.D. GEORGIA AVE, SILVER SPRING, MD. 19972. Registerra Signadure (d.4s 31. Date filed (Month, Days 1911 3 0 State



State of Maryland / Department of Health and Mental Hygiene 97 21438

## February Name (First Institution (Pase) was presented of number)  ## 6- February Name (First Institution (Pase) was presented by the Control of Death (Pa							Cei	rtificate of	Death		Reg. No.			•
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Second Score Number    Comparison   Comparis				4e. Fecility Name (If not institution	n, give street end num	nber)			4b. City, Town,					
Social Security Number   1,0 care   1,0 ca	7	Exami		5806 Sonoma Ro	ad				Rethesd	9	Monte	COMOR	37	
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Table   Informatics warmark-feelings company   Table   Informatics warmark-feelings company   Table	nd	al Hy oth		17. Father's Name (First, Middle,	Last)				18. Mother's N	lame (First, Middle	e, Maiden Surnar	ne)		
Table   Informatics warmark-feelings company   Table   Informatics warmark-feelings company   Table	/la	Vent Vent rked rice	2	Earl M. Broad	nurst				Hele	n M. Bos	1ey			
Description of the long state	al	sho ond h		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Stree	and Number or	Rural Route Numi	ber, City or Town	, State, Zip	Code)	
Silver Spring, MD 20901   Silver Spring, M	>	alth e		Regina M. Broad	dhurst		5806	Sonoma	Road, Re	thesda.	MD 2081	7		
Silver Spring, MD 20901   Silver Spring, M	ō,	f Had				20b. Pla	ace of Dispo	sition (Name of					own, State	
Silver Spring, MD 20901   Silver Spring, M	9	ege ant o t: If I				otate	-		•	6/20/07			***	
Silver Spring, MD 20901   Silver Spring, M		it. Partme				Met								
23. Part I. Etter the disease, or complexions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, entervisible Brewsen Onset and Death (President President). Approximate intervisible Brewsen Onset and Death (President). Approximate intervisible Brewsen Onset and Death	Ra	Deper Impo		* Feven L	Strong	7	Ho	ome, Inc	. 500 U	niversit	y Blvd.	West	lerar	
Physician (Modical Examiner)    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.				23a. Part1. Enter the disease, or	complications that ce	used the death.					arrest,	i	Approximat	le
The part of the pa		Physician		SHOOK, OF HOUSE IGHIGHS. CISE	only one cause on se	och mre.								
Due to (or as a consequence of):  Chronic alcoholism  Sequentially list conditions and a stripled of the strip	7				Caro	inoma	f the	1	-h	<b>.</b>			0	
Chronic alcoholism  Due to (or as a consequence of):  Due to (or as a cons		Examiner		resulting in death)	a. Carc.				in metas	tasis		-	2 yea	rs
Cause (Disease or Influry)  Fart II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.    23b. Did tobacco use contribute to the cause of death   1 12 12 12 10 10 10 10 10 10 10 10 10 10 10 10 10			Je		Chro							1	20	
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Cause (Disease or Influry)  Fart II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.    23b. Did tobacco use contribute to the cause of death   1 12 12 12 10 10 10 10 10 10 10 10 10 10 10 10 10	-6	axac n en el-tra	Exa	Sequentially list conditions, if any, leading to immediate		Due to (or	es a conseq	uence of):				1		
Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.    1	9	be sicient		Cause (Disease or Injury	c									
Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.    1	α	phy:	ğ			Due to (or a	as e conseq	uence of):				1		
Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.    1	×	ding	3		d									
Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.    1	9	ath c	<u>e</u>											
24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?  1   Yes 2   No 1	o.	the s	/sic	Part II. Other algnificant condition	na contributing to dea	ath but not result	ting In the u	nderlying ceuse g	iven in Pert I.	23b. Did	l tobacco uae co	ntribute to	the cause of	of death?
24a. Was an autopsy performed?  24a. Was an autopsy performed?  24b. Were autopsy findings available prior to complete on clause of death?  24c. Place of Death (Check only one)  25c. P	i	d by letac	Ph							1 🗵	Yes 2 No	3 ☐ Prof	bably 4	Unknow
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25. Wes case referred to medicel examiner?    26. Place of Death (Check only one)	ပ္ထ		ple							-		co	mpletion of c	
25. We case referred to medical examiner?  1		0 - 10	Eo							10	Yes 2 No	1.	TVes 2∏	No
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State   Stat	>	sicle cert iract	00	examiner?	Hospital:		D/O		hor:					
28f. Location (Street and Number or Rurel Route Number, City or Town, State)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Place of Injury - At home, farm, street, factory, office  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Eva Morell M.D., 6000 Executive Blvd., #300 Rockville, MD 20852  31. Date filled (Month, Day, Year)  32. Registrar's Signature	O	Phy reld						T 3LI DOA	4 □ Nursing				Y)	
28f. Location (Street and Number or Rurel Route Number, City or Town, State)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Place of Injury - At home, farm, street, factory, office  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Eva Morell M.D., 6000 Executive Blvd., #300 Rockville, MD 20852  31. Date filled (Month, Day, Year)  32. Registrar's Signature	ב	After fune	ion	1 Natural 5 ☐ Pendin	g (Month	n, Day Year)				200. 20001100	now injury occur	100		
29a. Certifier (Check only one)  29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and the discussion of person who completed cause of death (Item 23a) (Type, Print)  Eva Morell M.D., 6000 Executive Blvd., #300 Rockville, MD 20852  31. Date filled (Month, Day, Year)  32. Registrar's Signature	Š	tend death to:	cat	3 ☐ Suicide 6 ☐ Could i	not be						(0)		10 11	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and the discussion of person who completed cause of death (Item 23a) (Type, Print)  Eva Morell M.D., 6000 Executive Blvd., #300 Rockville, MD 20852  31. Date filled (Month, Day, Year)  32. Registrar's Signature	₹	fter of the ph	ŧ	dotorm	ined 288. Place of			eet, factory, office				er or Hure	il Houte Num	iber,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Eva Morell M.D., 6000 Executive Blvd., #300 Rockville, MD 20852  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		rate of leading and leading an	-											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Eva Morell M.D., 6000 Executive Blvd., #300 Rockville, MD 20852  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		Hosp 1 24 hou Fune eletaly fi	edical	(Check only 2 Medical	Examiner: On the bas	sis of examination	ledge, death on and/or inv	occurred et the t restigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time	cause(s) and ma , date and place,	anner as st and due to	tated. the cause(s	s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Eva Morell M.D., 6000 Executive Blvd., #300 Rockville, MD 20852  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		Withii To the		29b. Signature and title of certifies				29c. Licen	se number		29d. Date signe	d (Month,	Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Eva Morell M.D., 6000 Executive Blvd., #300 Rockville, MD 20852  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature				) (M	6 m. 1	MD		7	2006		6	201	97	
Eva Morell M.D., 6000 Executive Blvd., #300 Rockville, MD 20852  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature 33. Registrar's S	i	(0., ,		30 Name and address of account	veu	of dooth divers	72a) /T			3	0	20	1 /	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature									Dool	. 1/0	0052	,		
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 21439

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	Physic		Decedent's Name (First, Middle, La     Howard F. Brul								2. Date of D Month July	Day 1, 19	Year	Time of Death 3:47AM
1	/Medi		4a. Facility Name (If not institution, giv		ımber)				4b. City. To	wn. or Lo	cation of Dea	-	-	J. 471111
	Exami	ner												
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	Funeral		5. Social Security Number 6. S	iex ⊠M 2⊡F	7. Age (In yrs		Month:	er 1 Yea Day:		Min.	8. Date of B. (Month, D	ley, Year)	9. Birthplace Country)	(State or Foreign
	Director		210-44-0/03		90	Yı	8.				Feb. 1	0, 1907	Pennsy	lvania
	pu »		Usual Residence of Decedent  10a, State 10b, County		40- 0	ta. <b>T</b>								
	how I	-	10a. State 10b. County		10c. C	ny, rown	or Location							nside City Limits
	M J	9	Maryland Montgo	mery		Beth	esda						1	☐Yes 2∑No
	4 8 8 B	Director	10e. Street and Number				10f. Z	ip Code				10g. Citizen of	What Country?	
	30 of		5700 Harwick Road	d				208	216			United	States	
	eath eath	Funeral	11. Marital Status		cedent Ever in	IS	13 Was Dec			igin? (Spe	cify Yes or N		ce - American Ir	ndian
	Per d	E	1 Never Married 2 Married	Armed F	orces?	0,0	If Yes, sp	ecify Cu	ban, Mexicar	n, Puerto I	ecify Yes or N Rican, etc.)	Bla	ck, White, etc.	Toron,
20	9 8	by	3 Widowed 4 Divorced	If Yes, G	2 X No		1 ☐ Yes	2 🔯 No	Specify:			Specil	y:	
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덛	a H H	Be	17. Fether's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle	e, Maiden Sumar	me)	
<u>a</u>	should be filed within 72 hours efter death with the Marylend nd Mental Hygiena. marked other than "natural", or items 23e or 28e-f show unsafte event, the Medical Examinat must be notified at	To	Theodore Brubaci	h					Man	ry Vo	n Moss	5		
ar	sho arri	-	19a. Informant's Name/Relationship (	Type, Print)		19b. N	Mailing Addre	ss (Stree	et and Numb	er or Rure	A Route Numi	ber, City or Town	, State, Zip Coo	(e)
Σ	of the state of th		Jean B. Baines /	daught	er	662	1 Crox	For	v Driz	0 6	nringf	ield, Vi	rainia	22152
9	Hea Hea		20a. Method of Disposition	uada	000	D: -4 D	· 101 /0 /						- City or Town,	22152 State
٥	in the second of		1 X Burial 2 ☐ Cremation 3 ☐		State	cemetery,	crematory or	other pl	ace) July	y 3,	1997		0.1, 0.1.0,	
	mer mer jury		4 Donation 5 Other (Specification)	v)	Ce	dar l	Hill C	emet	ery			Suitlan	d, Mary	land
Baltimore, Maryland 21215-0020	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylen Depertment of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licer	100 11		0831			ress of Facili		1	15 1 1	on on	
m	80589		Darbara 15/1/c/	Mulkon	danse	nce						/Bethesda , Marylan		hase, Inc.
	Physician /Medical Examiner		23a. Per11. Enter the Msease, for com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on	eech line. iratory	, ins		ency		cardiac	respiretory	errest,	Ons	roximate rval Between set end Death hours
	P ==	ner		Seps	ic								8	days
	certificate be axecuted nding physicien and use es the burial-transit	Examiner	Sequentially list conditions	ь. Бере		or as a co	nsequence of	):						uays
o î	axe an ar rial-t		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	A				•						
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o	The law requires that the deeth ate hes been signed by the ette page 2 should be detached for	Physicia	Part II. Other aignificant conditions of	ontributing to d	leath but not re	sulting In the	he underlying	ceuse g	iven in Part I	l.	23b. Did	l tobacco usa co	ontributa to the	cause of death?
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Division of Vital Records,	he lav e hes age 2	E									1□	Yes 2⊠No	1 □ Ve	s 2 No
Ø	ilcian: Th certificate rector, pa		25. Was case referred to medical						00 81	-4.011		21		20110
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ō	Phys this ral di	<b>-</b>	27. Menner of Death	28a. Date	•	ER/Outp		JOA	4 L N			idenca 6 Ott		
L C	ding h. Aftar fune	ion	1 Neturel 5 ☐ Pending	(Mor	oth, Day Year)	Inju	iry	28c. Inj			zou. Describe	riow injury occur	ITEG	
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Ξ	or Attandi efter death. Director: A I in by the f	Certification:	4 Homicide determined	Zoe. Piec	e of Injury - At t ling, etc. <i>(Spec</i>	nome, farm <i>ify)</i>	n, street, fecto	ry, office	•	1	281. Location City or To	(Street and Num own, Stete)	ber or Rural Ro	ute Number,
	is election	ပီ			01									
	To the Hospital or Attanding Physician: The I within 24 hours efter death.  To the Funeral Director: Aftar this certificate he completely filled in by the funeral director, page	ca	29a. Certifier 1\(\infty\) Certifying Ph (Check only 2 Medical Exam	ysician: To the	best of my kn	owledge, o	leath occurre	d at the	time, date an	d placa, a	and due to the	cause(s) and m	anner es steted	l.
	he H	edlcai	one)	and mar	ner stated.	adon and/	or investigation	o, army	ориноп, деа	mi occurre	ou at the time	, date and place,	end due to the	Cause(s)
	To t To t	Σ	29b. Signature and title of certifier	//			2	9c. Licer	nse number			29d. Date signe	ed (Month, Day,	Year)
	12		Vonna	Ken		M	0	1	281	12 <		7/1	197	
			30. Name and address of person who	-homelated as	on of death the	m 000) /T	ma Pri-1\	4	201	ر ر		///	///	
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			Donna Rinis, M.D.	. bulli	L.X.P.C111	7376	KIVA .	SHI	TA KIII	I RO	CKWill	e. Mary	Land 2	DX52

State Registrar Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Deta of Death 3. Time of Death Buslovich Yaar **Physician** Month Kaisa 1030 AM 101 01 1997 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner SUBURBAN HOSPITAL **BETHESDA** MONTGOMERY If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number Birthplaca (Stata or Foreign Country)
 RUSSIA 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 81 Yrs. Director 220-23-2792 Usual Rasidanca of Dacedeni the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Medical Examinat must be notified at MONTGOMERY 1 ☐ Yas 2 No MD KENSINGTON Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 10920 CONNECTICUT AV, # 209 20895 USA Funeral 12. Was Dacedant Evar In U,S. Armed Forces? Was Dacadant of Hispanic Origin? (Spacify Yes or No If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian Black, White, etc. Pages 1 end 2 should be filed within 72 hours efter nent of Health end Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Yas 2 X No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Marriad Baltimore, Maryland 21215-0020 WHITE 1 ☐ Yas 2 No Specify: by 3 Widowad 4 □ Divorced Completed Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry College (1-4or 5+) Elemantery/Secondery (0-12) SURGEON MEDICAL 17. Father's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) YANKEL BUSLOVICH BLUMA SHAPIRO 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Numbar or Rural Routa Number, City or Town, Stata, Zip Code) permit. Pages 1 end 2 Depertment of Health er important: If item 27 Is any injury or other trau 10920 CONNECTICUT AVE #519, KENSINGTON MD 20895 SIMON BUSLOVICH BROTHER 20b. Place of Disposition (Nema of cematary, crematory or othar place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata PARKLAWN CEMETERY 7/3/97 ROCKVILLE, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signal of Fineral Sarvice Licensas 22. Nama and Addrass of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Enter the diseasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physiclan** EUROPENIC SEPSIS

Dua to (or as a consaquance of): /Medical Immadiata Causa (Final disease or condition rasulting in death) Examiner Examiner physician and the buriel-trensit The law requires that the deeth certificete be executed Sequantially list conditions, if any, laading to Immediata ceusa. Entar Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last P.O. Box 68760 Physician/Medical Dua to (or as a consequence of) for use es esn signed by the e Part II. Other algorificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was en autopsy parformed? pege 2 2 No 1 ☐ Yas 2 ☐ No certificate director. Be 25. Was cesa referred to medical 26. Placa of Daath (Check only ona) Other: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Yes 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA funeral 27. Mannar of Daath 28d. Dascriba how injury occurred 28b. Tima of 28c. Injury at Work? After 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be detarmined 3 Suicida 28f. Location (Straat and Numbar or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homiclde

Records, Division of Vital To the Hospital or Attending Physician: 24 hours efter death. Funeral Director: A filled in by within 2 To the

Certifying Physician: To tha best of my knowledge, death occurred et the time, dete end place, end dua to tha causa(s) and manner as stated.

Madicel Examiner: On tha basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceusa(s) and manner stated. 29a. Certifiar (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Dey, Year) causa of death (Item 23e) (Type, Print)

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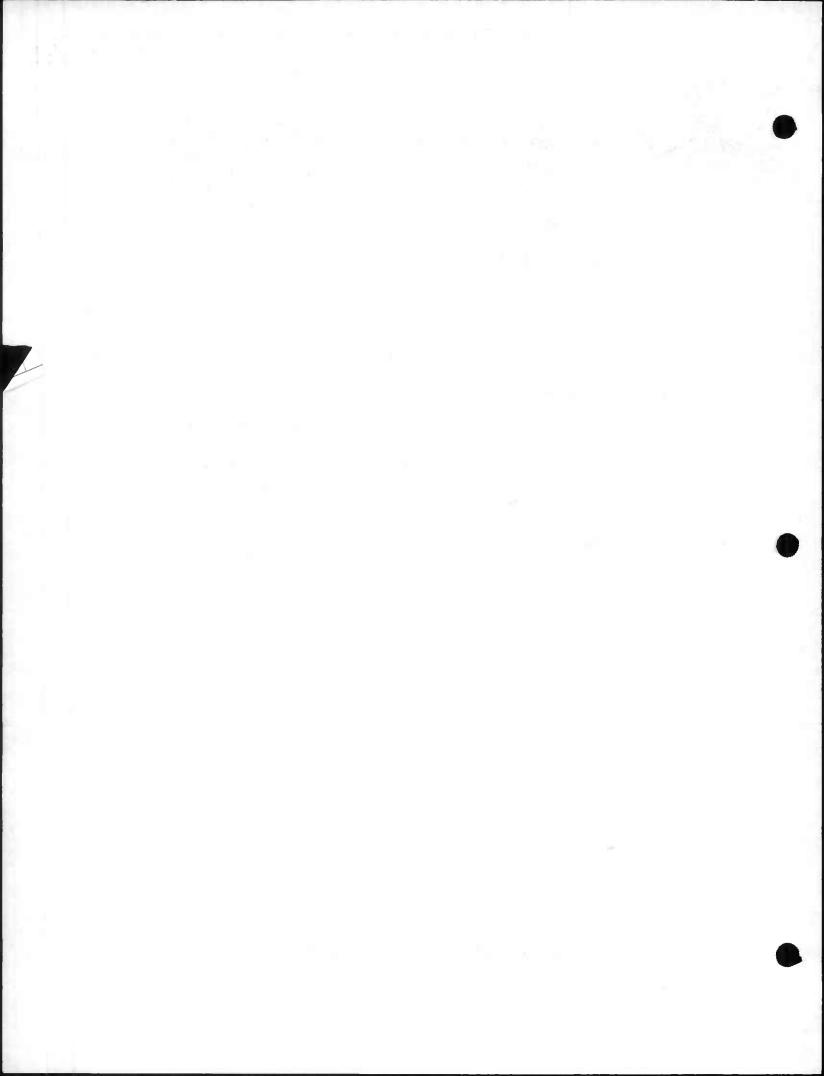
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State of Maryland / Department of Health and Mental Hygiene 97 2 | 44

					Cert	ificate of	Death	R	eg. No.	1 6	- 1 77 77 1	
	Dhyalai		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea		Year	3. Time of Death	
	Physici /Media			Frank Akos	Biro			June 16		1 Gai	12:15 AM	
1	Examir	ner	4a. Fecility Name (If not institution, give				4b. City, Town, or		4c. County	of Death		
			13899 Foggy Botto			If Under 1 Year	Mount Ai		Frede			
	Funeral Director		5. Social Security Number  577-68-0816  Usual Residence of Decedent	2 F 7. Age (III)	yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, April 3	1940		ace (State or Foreign y) gary	)
	yland		10a. State 10b. County	10c.	. City, Town or Loca	ation				10	d. Inside City Limits	
	e Mer	ctor	Maryland Frederic	k	Mount Ai	ry					1 ☐ Yes 2 No	
	or 28	Olre	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	What Counti	y?	
	23a	Funeral Director	13899 Foggy Botto	m Court	_	21771			United	Stat	es	
	terns terns	nue	11. Maritai Status	12. Was Decedent Ever in Armed Forces?	n U,S. 13. W	as Decedent of H Yes, specify Cuba	fispanic Orlgin? (S an, Mexican, Puerl	pecify Yes or No- to Rican, etc.)		e - America k, White, e		
Maryland 21215-0020	be filed within 72 hours eftar death with the Meryland that Hygiene. od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be nothing at	by	1) Never Married 2 Married 3 Widowed 4 Divorced	MYes 2 □ No If Yes, Give Year or Dates:	1955-	☐ Yes 2☐XNo	Specify:		Specify			
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d 2	filed within Hygiena.		17. Fether's Name (First, Middle, Last)	8	Engine	ering Co	nsultant	me (First, Middle, I	Archit		e	1
an	2 should be filed end Mental Hygi is marked other aumatic event,	To Be	Major Karoly Bi	ro			Maria		naraon oarnan	,		
ary	d 2 should th end Mer 7 Is marke traumatic	-	19a. Informant's Name/Relationship (T		19b. Mailing	Address (Street		ural Route Number	, City or Town,	State, Zip (	Code)	-
	27 tr		Peter A. Gruent	her	P. 0.	Box 268	. Clark	sburg, M	D 20871	-0268		
J.C.	of Healt Item 2		20a. Method of Disposition	20	b. Place of Disposi				20c. Location -			
E	Page Int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		Chesapeak			6-20-97	Reltsvi	11e.	Marvland	
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Funeral Service Licens		22.	Name and Addre	ss of Facility			110,	iar y rana	
CB	88 1 28		I Ellen &	. Kapp	93	pp runer 3 Gist A	venue. S	ces, P. <i>i</i> ilver Spi	A. Cina M	D 209	10	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that coused the d	leeth. Do not enter	the mode of dyir	ng, such es cardiad	or respiratory arr	est,		Approximate Interval Between	
1	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Arteriosclerotic Cardiovascular Disease  Due to (or as a consequence of):										
-	P Æ	iner	_	-						1		
	death certificete be axecuted e ettending physician end of for use es the burlal-transit	Examiner	Sequentially list conditions,	Due t	o (or as a consequ	ence of):						
60,	be ax ician burial		Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury	C								
68760,	phys s the	Medical	that initiated events resulting in death) Last	Due to	o (or as e conseque	ence of):				i		
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0	by the de	Physician/	Part II. Other algnificent conditions co		resulting in the und	lerrying ceuse giv	en in Part I.		oacco use co es 2□ No		the cause of death? ably 4 ☑ Unknown	
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Records,	raquir been s should	Completed t						24a. Wes e		com	e autopsy findings leble prior to spletion of cause eath?	٠
Re	The law ata has page 2	mo						1 X V	s 2 No		Yes 2□ No	
Vital		Be C	25. Was case referred to medical				26. Place of Dea	ath (Check only on				-
of <	Physician: this cartific ral director,	To	examiner? 1 🛱 Yes 2 🗆 No	Hospital: 1 ☐ Inpatient 2	2 ER/Outpatient	3□ DOA Oth	er: 4 Nursing H	iome 5 Reside	nce 6 Oth	er (Specify)		
n	fter th		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe ho	w injury occur	red		_
sio	Attanding F or death. ector: After by the funer	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No					
Division	2 0 0	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	At home, farm, stree ecify)	et, factory, office		28f. Location (St City or Town	reet end Numb , State)	er or Rural	Route Number,	
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	To the Hospital or A within 24 hours after To the Funeral Dire complately filled in b	edicai	29u Certifier 1  Certifying Phy 2  Medical Exami	eician: To the best of my I ner: On the basis of exam and manner stated.	nination and/or inve	stigation, in my o	ne, date and place pinion, death occu	rred at the time, d	ate and place,	inner as sta and due to t	he ceuse(s)	
	o the	Me	29b. Signaturyland title of certifier	and the state of t		29c. Licens	e number	2	9d. Dete signe	d (Month, D	ey, Yeer)	-
	5		Value	who ell	)	0	C M F		lune 1	6 10	0.7	
	_		30. Mame and address of person who co	ompleted cause of death (	Item 23a) (Type. P		C. M. E	•	June 1	0, 19	<i>j</i> /	
			Laron Locke, 1			•	ltimore,	MD 212	201			
ľ	Sta	te	31. Date filed (Month, Day, Year)	1997 Sulla								



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Deeth 3. Tima of Daath **Physician** Month Edward reckmar dune 1991 0620 H /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Daath **Examiner** SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY if Under 1 Year Months Days If Undar 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foraign Country) **Funeral** Months 1 X M 2 □ F Director 011-10-5292 June 28, 1910 87 Illinois Usual Rasidanca of Decedent 10a. Stata 10b. County 10c. City, Town or Location 28a-f show 10d. Insida City Limits 27 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examinar must be notified at 1 ☐ Yas 2 No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? permit. Pagas 1 and 2 should be filed within 72 hours aftar death a Department of Haelth and Mantal Hygiana. Important: If item 27 is merked other than "natural", or items 22-any injury or other traumatin avers. 20879 8440 Tea Rose Drive United States Funeral 14. Race - Amaricen Indian, Black, Whife, atc. 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Ricen, atc.) Armed Forces:
1 XYas 2 No
If Yas, Giva World
Yaar or Dates: War II 1 ☐ Navar Married 2 X Married 1 ☐ Yes 2 🗓 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedant's Education (Spacify only highast grade complated) 16a. Dacedani's Usuel Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry United States Elementery/Secondary (0-12) College (1-4or 5+) Executive Administrator Government 4 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be John P. Beckman Celia Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Numbar or Rural Routa Number, City or Town, Stata, Zip Code) Mary Helen Beckman / wife 8440 Tea Rose Drive, Gaithersburg, Maryland 20b. Placa of Disposition (Nama of cametary, cramatory or other place) July 9, 1997 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 
☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Arlington, Virginia 22. Nama and Addrass of Fecility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue, Rockville, Maryland M00831 20850-2805 23a. Pert1. Entar the dispase, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** immediata Cause (Finel disaasa or condition rasulting in deeth) a Gasterointest /Medical Examiner Due to (or as a consequence of): Completed by Physician/Medical Examiner Railiure attanding physician and for usa as the burial-transit The law requires that the death cartificate be executed Sequentially list conditions, if eny, leading to immediate causa. Entar Undarlying Ceuse (Disease or injury that initiated avants Dua to (or as a consequence of): struction 0 6 Dua to (or es a consaguance of) rasulting in deeth) Last (Advarad as t Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contributa to the ceuae of death? 1 Yes 2 No tach + curdin 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of ceuse of deeth? 24a. Was an autopsy performed 22 No certificata 1 ☐ Yas 1 □ Vas 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completally filled in by the funeral director, Be 25. Wes casa rafarred to medical axaminar? 26. Placa of Daath (Check only one) Hospital: Other: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) Certification: To 1 Yas 2 No 1 npatianf 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mapner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred Natural 5 Panding invastigation 1 TYas 2 No 2 Accident 6 Could not ba 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Sulcida 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 Homicide Certifying Physicien: To the best of my knowladga, death occurred at the tima, data and place, and dua to the ceuse(s) end menner es steted.

2 Medical Examinar: Or the basis of axamination and/or investigation, in my opinion, daath occurred at the time, date end place, end dua to tha ceuse(s) and manner statad. 29a. Certifiar Medical (Check only one) 29b. Signatura and title of certifier, 29d. Date signed (Month, Day, Yaar) Nous n Rashi U no complated gause of death (Item(23a) (Typ), Print) 30. Nama and eddrass of person who Suit

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relia Devidson-Randoles

MU 32. Ragistrar's Signature Rashid Baghai-Naini, M.D.

State Registrar

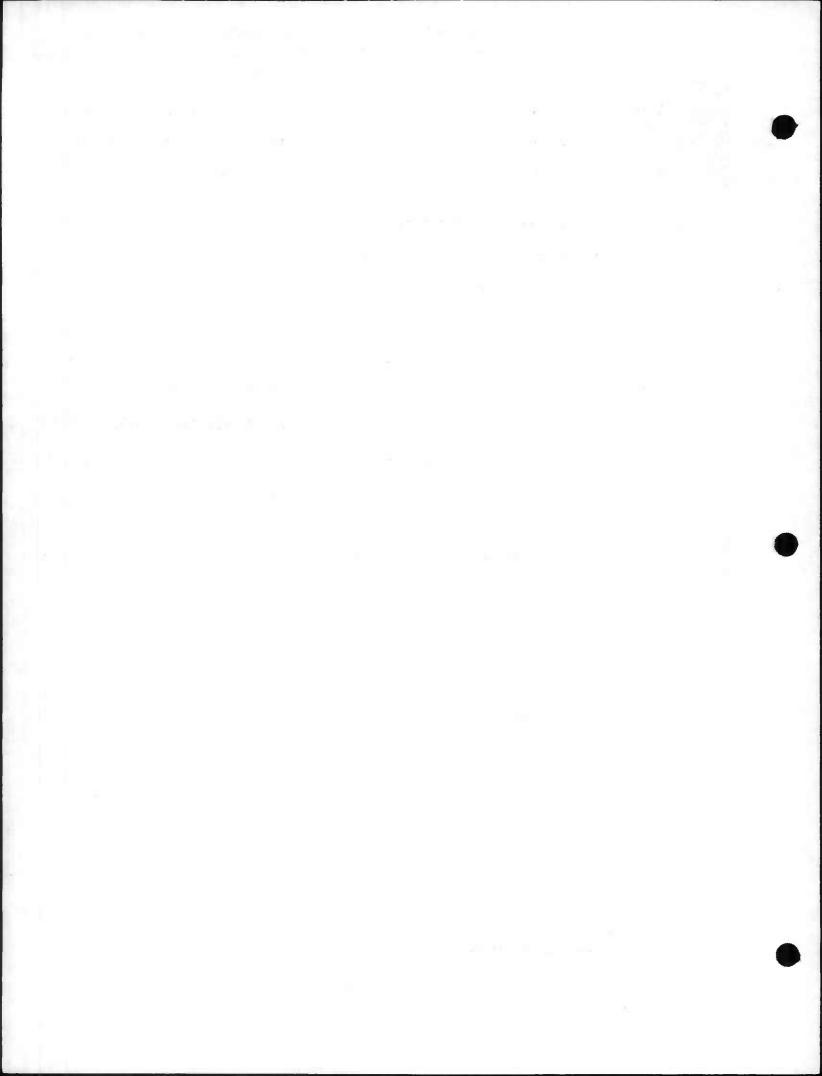
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

31. Date filed (M

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	Division		1. Decedent's Nama (First, Middle, La	st)		V.			n		2. Date of De		Day	Vans	3. Tin	ne of Death
	Physic /Medi		Robert	Hugh		Ba	SS				June 2	7,	1997	Year	10:	30 AM
	Exami		4a. Facility Name (If not institution, giv	e street and nur	n <i>ber)</i>			4	b. City, To	wn, or L	ocation of Deal		4c. County			
			2501 Newglen Aver						orest	vil	le		Princ			
н	Funeral		5. Social Security Number 6. S 521-30-6777	ex DXM 2□F	7. Age (In yrs.	last birthday) Yrs.	If Undar Months	Days	If Under	Min.	8. Date of Bi (Month, Di January	rth ay, Yea	ar) 020	9. Birthp	ace (St	ate or Foreign
	Director		Usual Residence of Decedent		67						January	11,	1930	Color	ado	
	ylend		10a. State 10b. County	-	10c. Cit	ty, Town or Lo	cation							10	Od. Insid	de City Limits
	Merish	tor	Maryland Prince (	George's	For	estvili	le								1 [X	Yes 2 No
	or 28	ire	10e. Street and Number				10f. Zip					10g.	Citizen of W	/hat Coun	try?	
	23a	Funeral Director	2501 Newglen Avenu	ıe			20	747				Un	ited	State	S S	
	er des	une	11. Marital Status	Armed Fo			Vas Deced f Yas, spec	ent of Hi	spanic Oni	gin? (Sp , Puerto	ecify Yas or No Rican, etc.)	)-		- Amarica k, White, e		n,
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21	od wit	Completed	12	5+	-401 34)	music	cian					f	ree 1	ance		
pu	tal Hy d oth	Be	17. Father's Name (First, Middle, Last)								a (First, Middla			a)		
Sla	ould Men marke	2	Rhuben Bass								aylor B					
Maryland	d 2 sh h and r is m traun		19a. Informant's Name/Relationship (	Type, Print)							al Route Numb					0747
a)	Healt Healt em 2		Jeanne O. Bass 20a. Method of Disposition		20b. F	2501 I	NEWGII	en A	venue	, F(	orestvi Date		Location -		_	0747
noi	ages ant of t: If It y or c		1 🕅 Burlal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi			sio Luthe				-	7-3-97		ke Pa			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature of Funeral Service Licer	*	LN		. Name an				3 31	Lu	KC TU	1 1 1	1 1 1 1 1 1 1	e 30 tu
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7	/Medical		Immediate Cause (Final disaese or condition	- Acut	e Myel	ogenous	Leul	cemia	a					4	- mo	nths
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Ö	s effe	Cert	* [] Hornicide	Dulidir	ng, etc. (Specif	у)					City or To	wii, Si	216)			
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			30. Name and address of person who	-			Print)									
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State Registrar



State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** June 29 1997 7:40 PM Evelyn Barnett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Montgomery

9. Birthplace (State or Foreign Country)

New York Suburban Hospital Bethesda If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) if Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 201F 87 Director 053-38-5618 Usual Residenca of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23e or 28e-f show other traumatic event, the Medical Examinar mainteen cities at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death a Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23e any Injury or other traumatic event, the Medical Examiner mans once. 8101 Connecticut Avenue 20815 United States Funeral Was Decedent Ever in U,S. Armed Forces? Was Decedeni of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by 3 Widowed 4 ☐ Divorced white Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samue 1 Safran Rose Gold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Barbara B. Wing 7810 Stratford Road, Bethesda, MD 20814 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Beltsville, Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Chesapeake Crematory 22. Name and Address of Facility
Rapp Funeral Services, P. A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 933 Gist Avenue, Silver Spring, MD 20910 **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last physician are the burial-tr Box 68760. Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown signed l þ 24a. Wes en eutopsy performed? 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed page 2 s 1 Yes 2K No 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2√ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28e. Date of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 Accident To the Hospital or Attending within 24 hours after death.

To the Funerel Director: Afte completely filled in by the fun 1 Yes 2 No 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. cai 29a. Certifier (Check only one) 29b. Signature and litle of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOG019 12 Name and address of person who completed cause of death (Item 23a) (Type, Print) 6410 ROCKLEDGE Drive BETHESDY MD 20817 TARRIS M KENNER, MO.

State Registrar 31. Date filed (Month, Day, Year)

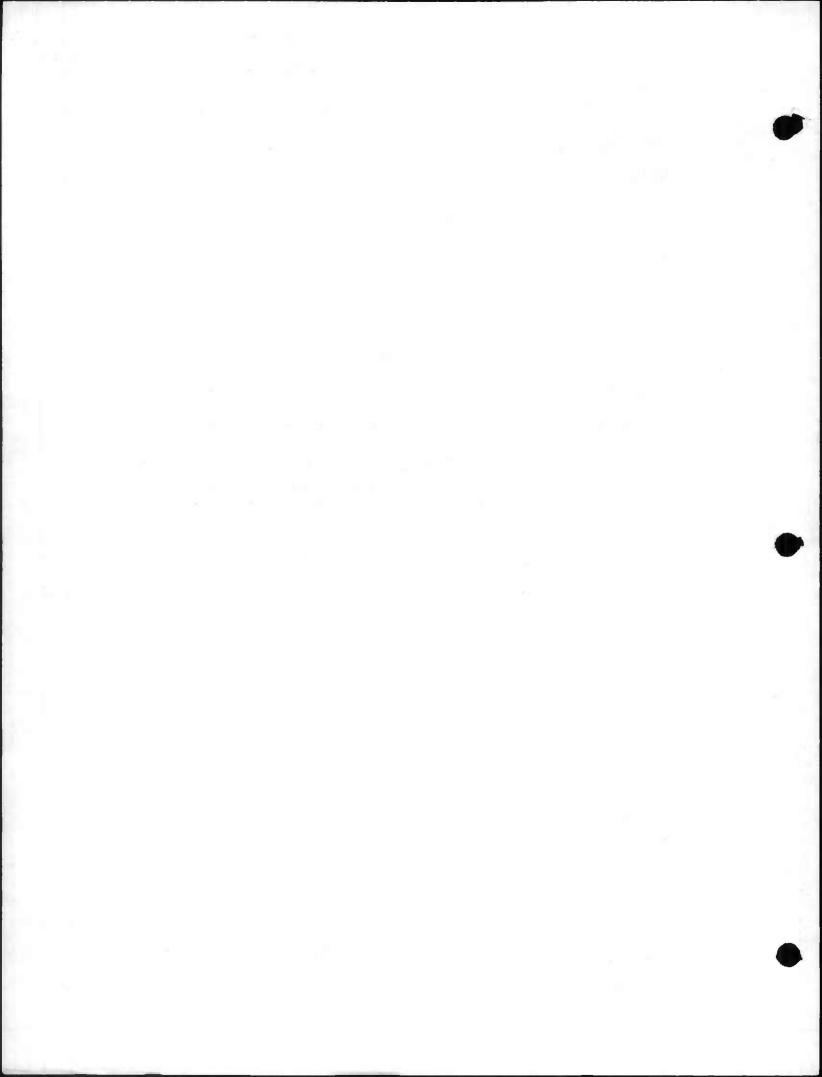
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32. Registrar's Signature

Julia Davidson-Randelle

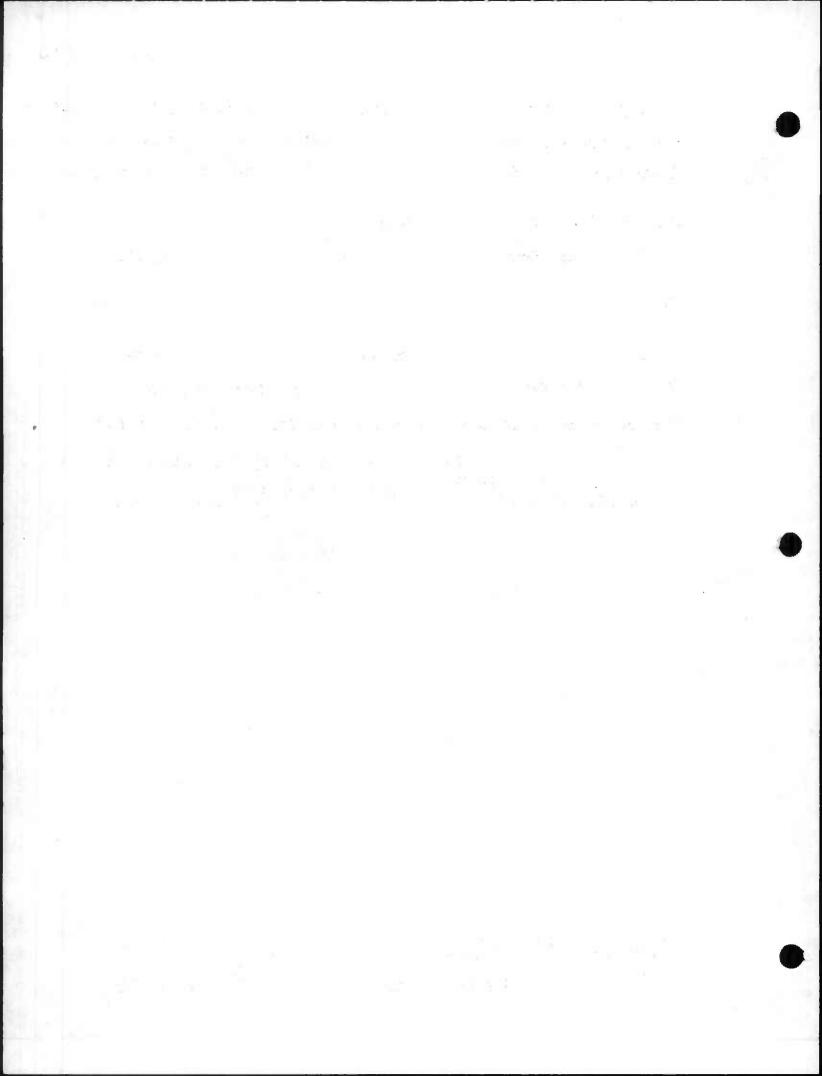
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Finis R. Burkhardt 1997 4c. County of Death 4b. City, Town, or Location of Deeth /Medical 5:00 AM 4a. Fecility Name (If not institution, give street and number) Examiner Doctors Community Hospital Lanham Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1XXM 2□ F 310 24 0855 88 Yrs. Indiana Sept. 6, 1908 Usual Residence of Decedent 10e State 10b County 10c. City, Town or Location 10d. Inside City Limits t⊠Yes 2 No Director Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of Whet Country? 13204 Idlewild Drive 20715 United States Funeral 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No þ Specify 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Wabash College 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Elizabeth Jane McCauley James C.Burkhardt 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 13204 Idlewild Drive Bowie Maryland Robert R. Burkhardt Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory June 27, 1997 Alexandria Va. 22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or cause on each line. Immediate Cause (Final disease or condition resulting in death) One week resistant Stanh aureous Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Darkinsonisum. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 Yes 2 No 1 Yes 2 No 25. Was cese referred to medicel examiner? 26. Plece of Death (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: 27. Menner of Death 28a. Date of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 TYes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Craifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 6.25.97 4 3446 30. Neme and eddress of person who completed ceuse of death (Item 23a) (Type, Print) 4000 Mitchelleville road B216 BowiE MD 20716 FARAHI FAR 12.0. 32 Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

JUN 3 0 1997

**Funeral** 

Director

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Division of Vital Records, P.O. Box 68760

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State of Maryland / Department of Health and Mental Hygiene 97 21447

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	Physic /Medi		ERIC EDWARD	BROOKS						JUNE	De		eer 7	110	5PM
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	ath with the Maryland 23a or 28a-f show ust be notified at	tor	Usual Residence of Decedent  10a. State 10b. County  DC N/A		10c. City, Town								10	od. Inside Cit	
	with the	Director	10e. Street end Number 1553 ANACOST	TA AVENUE	NF #14	10f. Zip	Code	19			_	itizen of Wh	et Count	ry?	
020	or Items	by Funeral	11. Marital Status SINGLE  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:	ver in U,S.	13. Wes Deced	ent of ify Cub	Hispenic Orl en, Mexican	gin? (Sp.	ecify Yes or No Ricen, etc.)		14. Race -	White, e		
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o uc	ling Phy After thi funerel		27. Menner of Deeth Natural 5 Pending	28a. Date of Injury (Month, Day	28b. Tin	ne of 28	Bc. Inju Wo	ry et rk?		28d. Describe					
Division of	To the Hospital or Attending Phwithin 24 hours either deeth. To the Funerel Director: After the completely filled in by the funerel	Certification:	2	28e. Place of Injur building, etc.		M , street, factory,		Yes 2 □ f		28f. Location (S City or Tox			or Rural	Route Numb	er,
	To the Hospital or within 24 hours effection to the Funerel Diraccompletely filled in	edicai C	29a. Certifier (Check only one)	sician: To the best of ner: On the basis of e end manner state	examinetion end/o	eeth occurred e	t the ti	me, dete end opinion, deat	d plece, o	end due to the ed et the time,	ceuse(s dete en	) end menn d plece, end	er es ste d due to t	ted. the ceuse(s)	
	To the compl	Me	29b. Signature and title of certifier	Bue				se number	2			ite signed (i			27
	1.1)	1	30. Name end eddress of person who co	ompleted ceuse of dee	eth (Item 23e) (Ty	rpe, Print)	P	601	md	2015	76				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrer	's Signature	i pro			1114.	0010					

Walter St. W. M. M. M.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dey raswel nora 28 9 PM June 97 /Medical 4a. Fecility Neme (If not institution, giva street end number) 4t City, Town, or Location of Death 4c. County of Deeth **Examiner** Baltimore Co. eaton umms Baltimore Hours Min. Feb. 11, Year 946 5. Social Sacurity Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Yaar 9. Birthplace (Stete or Foreign **Funeral** Days 578-64-8681 Months 1 ☐ M 2 💢 F 51 Wilson, N.C. Yrs. Director Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Marylend nent of Health end Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits / is marked other than "natural", or items 23a or 28a-f sho traumatic event, it a Modical Examiner must be notified at MD Prince George's Temple Hill Director 1 X Yas 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2503 Oxon Run Drive items 23a 20748 United States America Funeral 12. Wes Decadent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 25 No if Yes, Give Year or Dates: Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indien, 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 Black 1□ Yes 2□No by Specify 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Executive Secretary Private 17. Fethar's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumeme) Be h end Mental I James Braswell Anne L. Foster <sup>o</sup> 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2503 Oxon Run Drive, Temple Hill, MD 20748 permit. Peges 1 end 2:
Department of Health er
Important: If Item 27 is
any injury or other trau Anne L. Braswell / Mother 20b. Place of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, State cametery, cremetory or other place)
Harmony Memorial Park 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removel from State 7/3/97 Landover, Maryland 4 Donetion 5 ☐ Other (Spacify) Funaral Service Ligan 22. Name and Address of Fecility
Sterling Funeral Services Dulence 1601 Kenilworth Avenue, NE; Washington, DC 23e. Part Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner To the Hospital or Attending Physician: The law requires thet the deeth cartificete be executed within 24 hours effect death.

To the Funeral Director: After this cartificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the builet-transit completely filled in by the funeral director, page 2 should be deteched for use as the builet-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseesa or injury that initiated events resulting in deeth) Last Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or es a consequenca of): been signed by the e should be deteched t Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Unknown 1 ☐ Yee 2 ☐ No 754chosis by 24b. Were eutopsy findings aveileble prior to completion of causa of deeth? Completed 24e. Wes en eutopsy performed? Que fri tron 1 Yes 1 ☐ Yas 2 ☐ No Anemio 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitai: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) 1 Yes 2 No £ 27. Menner of Deeth Medical Certification: 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicida 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier (s) earlifying Phyaician: To tha best of my knowledge, deeth occurred et the tima, dete end pleca, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, date end place, end due to tha ceuse(s) end menner steted. 29b. Signetura and title of certifie 29c. Licansa number 29d. Dete signed (Month, Dey, Year) completed cause of deeth (Item 23e) (Type, Print) S. Charles Street 31. Dete filed (Month, Day, Year) State

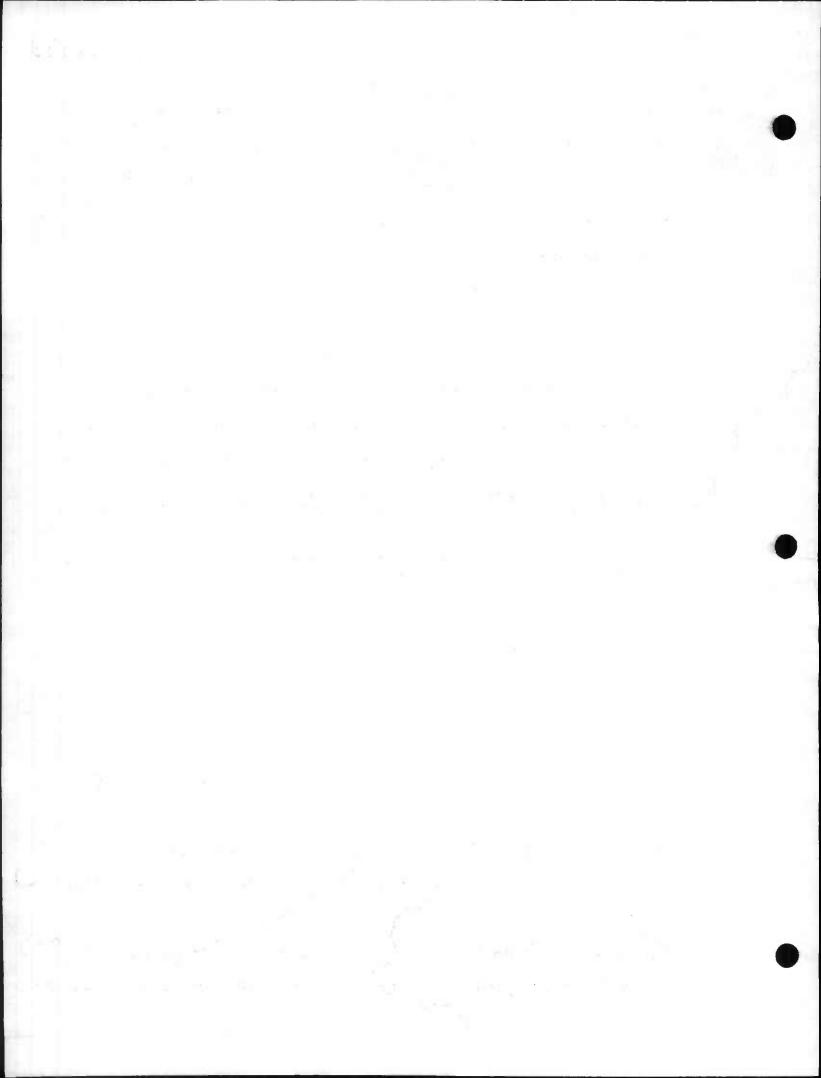
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ľ	Physici		Decedent's Name (First, Middle     Betty Lou CORE						2. Date of De- Month		Year 1997	3. Time of Death
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	Funeral Director		GARRETT COUNT 5. Social Security Number 213-72-1790	6. Sex 7. Aç	L HOS ge (in yrs. les 40			OAKLAN If Under 24 Hrs Hours Min	8. Date of Birt	y, Year)	9. Birthpl Count	COUNTY lece (Stete or Foreign try) Virginia
	and w		Usual Residence of Decedent  10e. State 10b. County		10c. City.	Town or Lo	cation					0d. Inside City Limits
	Maryla f sho	ō		rett	,		land					1 ☐ Yes 2 ☑ No
	r 28a	Director	10e. Street end Number	1000		- Oak	10f. Zip Code			10g. Citizen of \	Whet Count	try?
	th with		348 Snow Dump	Mountain Roa	ad		2	1550		US.	A	
070	72 hours after death with the Maryland "natural", or items 23s or 28s-f show orlical Examinet must be notified at	by Funeral	11. Maritel Status  1 □ Never Married 2 ☑ Merri 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? ied 1 ☐ Yes 2 ☐ If Yes, Give Yeer or Detes:	July 1		Was Decedent of F f Yes, specify Cub 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sen, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	- 14. Rad Bla Specifi	e - America ck, White, e	
1215-0020	filed within 72 hou I Hygiene. other than "natural ant, the Medical E	Completed I	15. Deceden (Specify only higher Elementery/Secondary (0-12)	t's Educetion		(Give	dent's Usuel Occup kind of work done DO NOT use retire	during most of wa	orking	16b. Kind of B	usiness/Ind	lustry
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Maryland	2 2 2	o Be			Robie				me (First, Middle, Irene Si			
2	should ind Men imarke umatic	Ĕ	19a. Informent's Name/Reletions		RODIC		ng Address (Street					Code)
	and 2 ealth ai n 27 is		A. Craig Corby				now Dump				215	
Baltimore,	permit. Peges 1 an Department of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposition 1 ☐ Buriel 2 ☒ Cremation 4 ☐ Donetion 5 ☐ Other (S		20b. Ple cen	ce of Dispo netery, crer	sition (Neme of natory or other ple ematory		Date	20c. Location -		
Balt	permit. Departr Imports any Inje		21. Signature of Funeral Service	Lionage	,		Stewart 32 S. See	Funeral I	Home Oaklan	d MD (	21550	
			23a. Pert1. Enter the disease, or shock, or heart failure. List	complications thet caused only one cause on eech li	d the deeth.						11330	Approximete Intervel Between
	Physician /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in deeth)	a	Mu	Hipe	le I	Murie	\$			Onset end Death Sudden
		je.			Due to (or e	es e conseq	uence of):	ŧ				
	ficete be executed physician end is the burial-transit	Examiner	Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying	6	Due to (or e	es e conseq	uence of):					
58760,	e be exision sician	edicai E	ceuse. Enter Underlying Cause (Diseese or injury thet initieted events	c	Due to for e		vence of).					
BOX 68	certifi ding	lan/Medi	resulting in deeth) Lest	d	Due to (or e	s e conseq	uence or).					
ה ה	death he atter ed for u	sicia	Pert II. Other significant condition	ns contributing to death b	ut not resulti	ing in the ur	nderlying ceuse giv	ven in Pert I.	23b. Dld 1	obacco use co	ntribute to	the cause of death?
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ecord	aw requires been so should	Completed					_			en eutopsy rmed?	con	re autopsy findings illable prior to npletion of cause deeth?
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5	ath. :: After e funer	ation	1 ☐ Naturel 5 ☐ Pendin 2 Accident investig	(Month, De	y Year)	Injury 2205	28c. Injur Wor M 1 🗆	k? Yes 2∭ZNo	Daile	~ .	£ (	sile of
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	the Hospi in 24 hou the Funer pletely fill	edicai	29a. Certifyin (Check one)  1 Certifyin 2 Medical I	g Physician: To the best Examiner: On the basis of and manner st	examination	edge, death n end/or inv	occurred et the tin estigation, In my o	ne, date end place pinion, death occu	e, end due to the durred et the time, d	eeuse(s) end me date and place, o	nner es ste end due to	nted. the cause(s)
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	Sta Registr		31. Date filed (Month, Day, Year)	1997 32 Hegistr	ar's Signatur	- Ravelo	16					



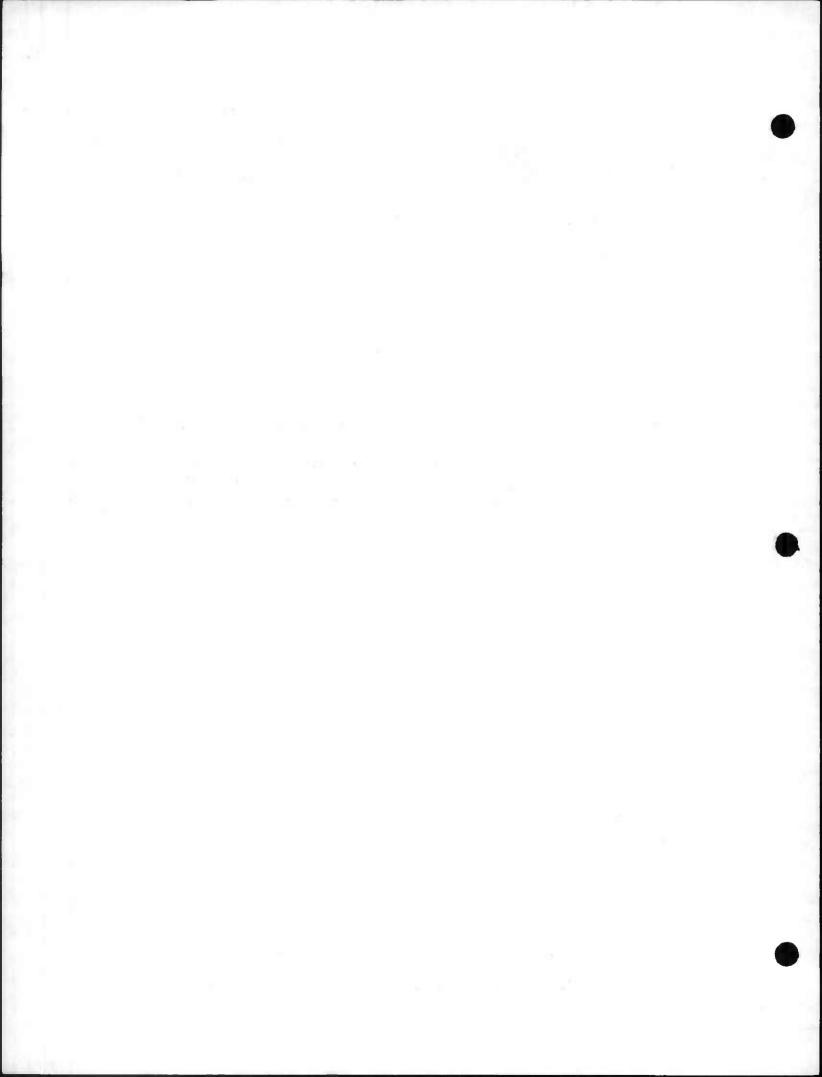
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Physic	ian	Decedent's Name (First, Middle, Last)					2. Dete of De Month	Dev Y	3. Time of Death
/Medical		HELEN REED CLARK					June		197 720pm
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illed within 72 hours effer death with the Maryland Hygiene. When than "naturel", or items 23a or 28a-f show out, the Medical Examiner must be notified at	Completed by Funeral Director	Usuel Residence of Decadent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits							
		Maryland Harford Bel Air							1)∑ Yes 2 □ No
		10e. Street end Number			10f. Zip Code			10g. Citizen of Whet Country?	
		29 Homestead Street			21014			USA	
		11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Yeer or Dates:			r in U,S.  13. Wes Decedent of Hispenic Origin? If Yes, specify Cuben, Mexican, Put  1 □ Yes 2 No Specify:		pecify Yes or No- o Rican, etc.)  14. Race - American Indien, Bleck, White, etc.  Specify: White		White, etc.
n 72 ho "natur		15. Decedent's Education (Specify only highest grade completed)		16e.	16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)		king	16b. Kind of Business/Industry	
filed within 72 hours eft Hygiene. ther than "naturel", or out, the Med cal Evan		8 College (1-40r 5+) Homemaker						Own Home	
be filed itel Hygid d other event,	Be	17. Father's Neme (First, Middle, Last)						Maiden Sumame)	
should end Men s marks	2	Harry Reed Coale				Sarah Estell Kerr			
		19e. Informant's Name/Relationship (7)			Meiling Address (Street				
Heal ther		Samuel Magness - S  20e. Method of Disposition	Son	-	Homestead				
		1 ☐ Burial 2 ☐ Cremetion @ ☐ F	Removal from State		Disposition (Neme of cremetory or other pla		Dete	20c. Location - Ci	
t. Partmentant:		4 □ Donetion 5 □ Other (Specify)	1.1	Bel Ai	r Memorial				, Maryland
permit. Pages Depertment of Important: If it any Injury or once.		21. Signetified Funeral Service Uses as Park Property Language and Address of Fecility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009							
Physician /Medical Examiner	edical Examiner	Due to (or es a consequence of):						5 days	
ifficete be executed g physician end es the buriel-transit		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initieted events	Due to (or es e consequence of):  c.  Due to (or es e consequenca of):						
= 00 0	Physician/Med	resulting in deeth) Lest	d	(0,000					
e dea he et	sici	Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause gi				ven in Pert I.	23b. Dld t	obecco uee contri	bute to the cause of death:
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S S C	Completed	Encephalopathy.						en eutopsy rmed?	24b. Were eutopsy findings aveileble prior to completion of cause of deeth?
To the Hospital or Attanding Physician: The I within 24 hours effer deeth.  To the Funeral Director: Affer this certificate he completely filled in by the funeral director, page	Be						1 🗆 Y	es 2 No	1 ☐ Yes 2 ☐ No
		25. Wes case referred to medical exeminer?	Inneitale			26. Place of Deel	th (Check only o	ne)	
	2	1 Yes 2 No Hospitel: 1 Inpatient 2 EH/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Menner of Deeth 28a. Dete of Injury 28b. Time of 28c. Injury et 28d. Describe how injury occurred							
	ion	27. Menner of Deeth  Neturel 5 ☐ Pending	me of 28c. Injui ury Wo M 1□	rk?	28d. Describe h	ow injury occurred			
	Certification:	2 ☐ Accident investigation 3 ☐ Sulcide 4 ☐ Homicide				Yes 2□No	281. Location (Street and Number or Rurel Route Number, City or Town, State)		
	edical (	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pieca, end due to the ceuse(s) and menner es steted.  2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) end menner steted.							
To the To the Somp	₩.	290. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year)							Vionth, Day, Year)
		1 few lyne my D350				5012			
10		30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)  J. Kevin Lynch m.B. 2 North Ave. Belair, Md. 21014							
Sta		31. Dete filed (Morth, Pay, Year) 196		s Signature					

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State of Maryland / Department of Health and Mental Hygiene 2 1 4 5 1

						Certin	ficate of	Death		Rag. No.		
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	aryta ahov d.at	-			10c. City, 14	own or Locati	on				100	d. Insida City Limits
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	ours after death with the Maryla ns', or items 23e or 28e-f show Examiner mast be notified at	Funeral Director	11. Marital Status	12. Was Decedent 8 Armed Forcas?		13. Was	Decedant of as, specify Cub	Hispanic Origin? (Spoan, Maxican, Puerto	ecify Yas or No Ricen, atc.)	- 14. Ra Bla	ce - Amaricer	
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	be filed tal Hygi d other event, II		17. Father's Nema (First, Middle, Las	t)	44	DDOCIO	oc bpc	18. Mother's Nam			nsuran	ce
Maryland		To Be	Dorset T.	Carr				Dorot		VanSluy		
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e,	- 운동등		20a. Method of Disposition	(DISCE)	20b. Place	of Disposition	n (Nama of		Dete	20c. Location		n. Stata
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Baltimore	Sermit. Pa Separtmen important: any injury ance.	1	21. Signature of Funeral Service Lice		Geor		ningto	n Cemeter			hi, Md	
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ita	ysician: The s certificate director, pag	Be (	25. Was casa raferred to medical axaminer?					26. Place of Deet	h (Check only o	one)		
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Division of Vital Records,	ding Ph h. After th funeral		27. Manner of Death  1. Natural 5 □ Panding	28a. Data of Injury (Month, Day	y Year) 28b	. Tima of Injury	28c. Inju Wo	ry at	28d. Dascribe	how injury occur	red	
Sio	Attending in death.  actor: After by the fune	Certification:	6□'Accidant invastigation	n				Yas 2□No				
$\equiv$	or Attendent after deat Director: J in by tha	ŧ	3 ☐ Suicida 6 ☐ Could not to datermined	28a. Place of Inju- building, atc.	ry - At homa, . (Specify)	farm, street,	factory, office		28f. Location ( City or To	Street and Numl	per or Rural F	louta Number,
	To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by tha funeral											
	Hospital 24 hours Funeral stely filled	edicai	(Uneck only 2 Medical Exa	nysician: To the best of miner: On the basis of o	f my knowlade	ge, daath occ	curred at tha til	ma, date end place,	and dua to tha	ceusa(s) and ma	anner es state	ad.
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		-	29b. Signetura end titla of certifiar	651			29c. Licens	se numbar		29d. Date signa	d (Month, Da	y, Year)
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			30. Nama and address of person who	complated ceuse of da	ath (Itam 23e	(Type, Prin	()	4			1	
			7610 Carrall +	ne. to	akon	in Pa	all,	MD	20912	2		
	Sta	te	31. Data filed (Month Gay, Car	997 32. Registra	's Minature	Bank	00					

					Cei	rtificat	e of	Death		R	leg. No.			
Discola		1. Decedent's Neme (First, Middle, Las	st)							2. Dete of Dee Month		Vone	3. Tim	e of Death
Physic /Medi		Nancy Chow								June 26	, <sup>D</sup> 1997	Yeer	7:2	0 A.M.
Exami		4e. Fecility Name (If not institution, give Suburban Hospital		um <i>bar)</i>				4b. City, Tov Bethe		cation of Daeth	4c. County Monts	of Deeth	у	
Funeral Director		213 30 0070	ax □M2∏XF	7. Age (In yrs. la 76	est birthday) Yrs.	If Under Months			Min.	8. Deta of Birth (Month, Dey June 7,		9. Birthp Coun Chin		ate or Foreig
and w		Usuel Residence of Decedent  10a. Stete 10b. County		10c. City,	, Town or Lo	cation						10	Od. Insid	le City Limits
he Mary 28a-f sho	Director	MD Montgome	ry	Chev	y Cha	-				1 □xYes 2 □ N				
with with the second		10e. Street end Number 4701 Willard Ave.	#217			10f. Zip					log. Citizen of	Whet Coun	itry?	
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C . 0	Completed	Elementery/Secondary (0-12)		(1-4or 5+)			se ratir	e during most ad)	OI WOIKII		Nationa		cati	ion
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2 should by and Menta is marked eumatic ev	F	19e. Informant's Name/Relationship (7	ype, Print)		19b. Meilir	ng Address	s (Stree	et end Number	r or Rura	l Route Number	r, City or Town	, State, Zip	Code)	
1 and 2 s Health ar em 27 is other treu		Diane Lu Nie	ce		611 S	. Vis	sta	Avenue	e, A1	Lahambra	a, Cali	forni	a 91	1801
es 1 and of Health f Item 27 r other tr		20e. Method of Disposition  1 Buriel 2 Cremation 3	Demovel from	20b. Ple	ece of Dispo metery, cren	sition (Name	ne of other pl	ece)		Date	20c. Location	- City or To	wn, Stet	е
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permit. Pages Department of Important: If is eny injury or once.		4 Donation 5 Other (Specify)  Gate Of Heaven Cemetery 6/30/97 Silver Spring, MI  21. Signature of Fourier Service Licensee  22. Name end Address of Facility Joseph Gawler's Sons Inc.  5130 Wisconsin Avenue, NW, Washington												
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ertificate be executed Jing physician and se as the burial-transit	Medical Examiner	Sequentially list conditions, if eny, laading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest	b	Due to (or Selle	es e conseques e c	(uence of):	ra	elej	e ped,	del De li	leo Leael			
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Physicien: rthis certific ral director,	ဥ	ILI Tes ZLYNO	V		R/Outpetien		JA			na 5 Reside			1)	
After fune	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		nth, Day Year)	28b. Time of Injury	М		Yes 2□N	10	28d. Describe ho				
Ital or At		4 Homicide determined	28e. Place	e of Injury - At hom ing, etc. <i>(Specify)</i>	ne, farm, str	eet, factor	y, office	•	2	28f. Location (Si City or Town		ber or Hura	/ Houte /	Vum <i>ber</i> ,
To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one)  Check only 2 Medicat Example 1	Iner: On the b	e best of my knowled basis of exeminetic oner steted.	ledge, deeth on end/or inv	occurred estigetion	et the t , in my	ime, dete end opinion, deat	d place, e h occurre	end due to the co	euse(s) end me late end place,	enner es st end due to	eted. the ceu	se(s)
	X	29b. Signature and title of certifier				290	C. Licen	se number		_	9d. Data signe			ar)
12		30. Neme end address of person who o	empleted cause	se of deeth (Item 2	23e) (Type	Print)	)	231	1	0 .	June 26	, 199	7	
		Gita Bakshi, M.D.		Old Geo			ad.	Bethe	sda.	MD 208	314			
Sta	ate	31. Dete filed (Month, D11, Mea)		Registrar's Signatu			,		,					



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day **Physician** 1997 June 30, Carol Anne Clark 5:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** 10204 Crested Iris Drive Gaithersburg Montgomery | Months | Days | Hours | Min. | Sept. 23, 1940 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Country) Yrs Director 355-32-1369 56 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 7 is merked other than "natural", or items 23e or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Montgomery Marvland Gaithersburg Direct 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 10204 Crested Iris Drive 20879 United States permit. Pages 1 and 2 should be filed within 72 hours efter deeth v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Exemples Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XX\\0 If Yes, Give Yaar or Dates: 1 ☐ Yes 2\(\times\)\(\times\)\(\times\) Specify: Specify ð 3XXWidowed 4 □ Divorced White Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Justice 12 Budget Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Collins Arthur James 20 Esther Dorothy Dell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne E. Clark Same as 10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Spacify) Chesapeake Crematory 7-1-97 Beltsville, Maryland 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 Approximate Interval Batwaen Onsat and Death 23a. Part1. Enter the disaase, or complications that ceusad tha daath. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failura. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition rasulting in death) Metastatic Breast Cancer 5 years Examine Due to (or as a consequence of) Examiner physician end the buriel-transit Sequentially list conditions, if any, leading to immediate ceusa. Entar Underlying Cause (Disease or Injury that initieted events resulting in death) Last Dua to (or as a consequence of): Physician/Medical Due to (or es e consequence of) 80 use i ed by the e Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t by should t 24b. Wara autopsy findings evailable prior to complation of cause of daath? 24a. Was an autopsy performed? Completed has 2 X No 1 ☐ Yes 1 ☐ Yes 2 ☑ No 25. Was cesa raferred to medicel examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Othar: 4 Nursing Home 5 NesIdence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Daath 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After 1 XNatural 5 Pending or Attandin efter death. Director: Aft 1 ☐ Yes 2 ☐ No Investigation 2 Accident Could not be datermined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) filled in by 4 Homicida 24 hours e 29a. Certifier edicai 1 Certifying Physician: To tha best of my knowledga, daath occurrad at the time, data and place, and dua to tha causa(s) and mannar as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and titla of certifier 29c. License number 20 July 1, 1997 30. Name and addrass of person who completed cause of deeth (Item 23a) (Type, Print) Stephen Staal, M. D., 10810 Connecticut Avenue, Kensington, MD 20895 32. Registrar's Signature

Julia Davidson-Randalle

State Registrar

JUL 02

with the Meryland

Baltimore, Maryland 21215-0020

certificate be executed

Box 68760.

P.O.

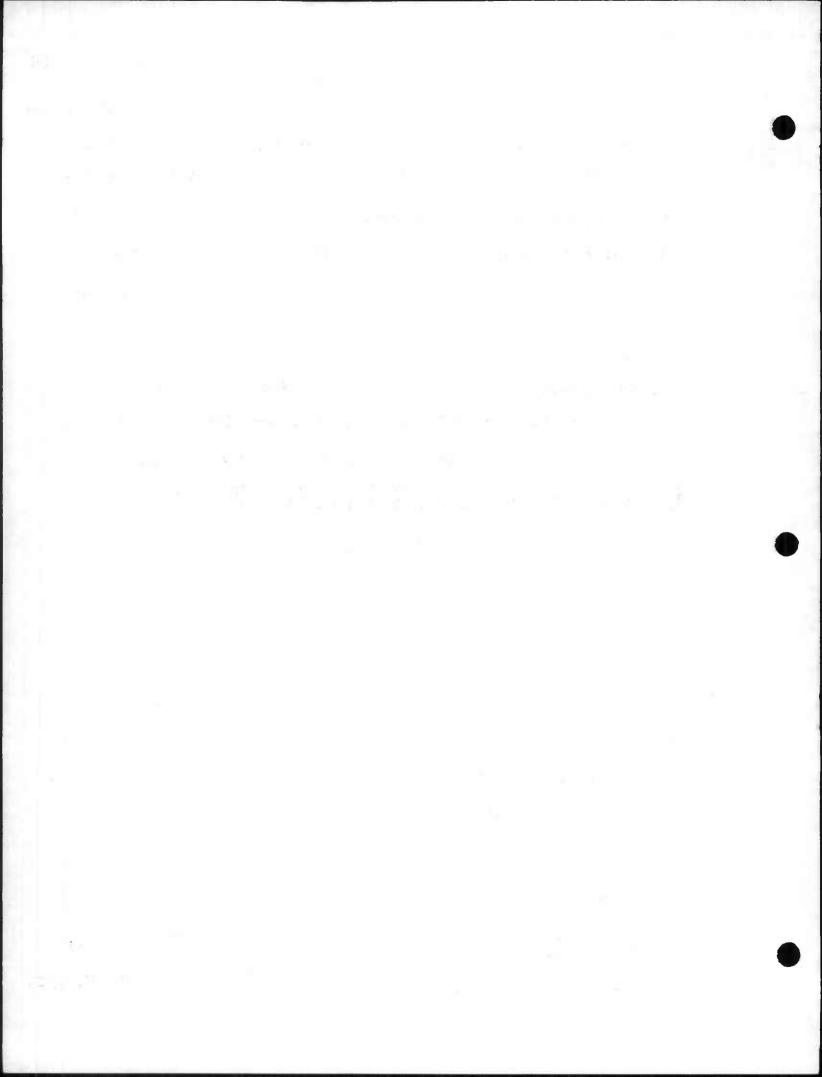
Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene 97

97 21454

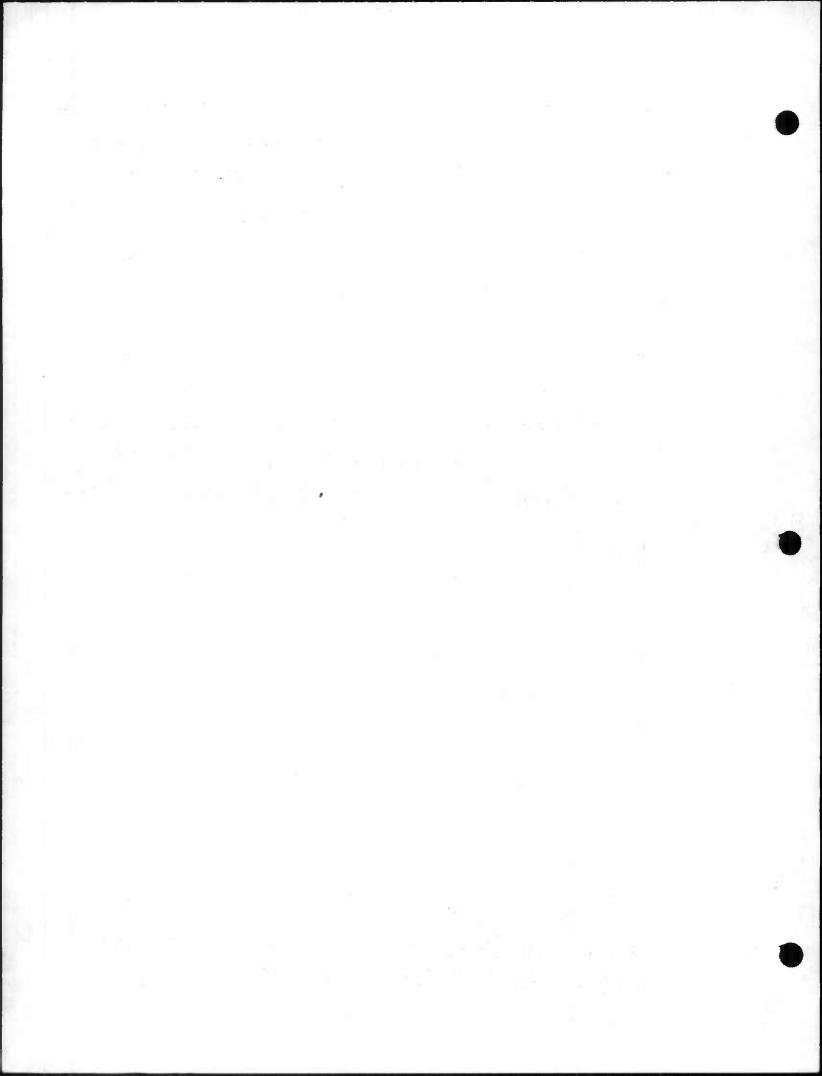
					Cert	ificate of	Death		Reg. No.	1	21707
	Dhusin	ion	Decedent's Name (First, Middle, Lest)					2. Date of De		Voor	3. Time of Death
	Physic /Medi		LUCY FRANCI	25 CO	LEM	IAN		JUNE	24	1997	1407 Am
	Exami		4a. Facility Name (If not institution, give street end n	umber)			4b. City, Town,	or Location of Death	4c. County	of Deeth	
			SHADY GROVE ADVENTIS				ROCKV		MON	MIGOM	ERY
т	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bi	irthday) Yrs.	Months Deys		Min. (Month, De	v. Yeer)	9. Birthp Coun We	lace (Stete or Foreign
	Director		Usual Residence of Decedent	48	115.		1	May 2	1,1949	we	st VA
	and was		10e. State 10b. County	10c. City, Tow	vn or Loca	ation				1	0d. Inside City Limits
	Mary -1 sh	to	MD Montgomery	Re	ockv	ville					1⊠Yes 2□No
	r 28a	iec	10e. Street end Number			10f. Zip Code			10g. Citizen of V	Vhet Coun	itry?
	h with	al D	316 Lincoln Avenue	<u> </u>		2085	50		U.S	S.A.	
	deat	Funeral Director	11. Marital Stetus 12. Was De	cedent Ever in U,S.	13. W	as Decedent of	Hispanic Origin	? (Specify Yes or No uerto Rican, etc.)		a - Americ	
21215-0020	filed within 72 hours after death with the Maryland Hygiena. ther than "natural", or flems 23a or 28a-f show ont, the Med cal Exarterer must be notified at	by		2 <b>∑</b> No Give		☐ Yes 2XXX		dello moan, etc.,		Bla	
5-0	72 h	Completed	15. Decedent's Education (Specify only highest grede completed	16e	. Decede	nt's Usual Occu	upetion e during most of	working	16b. Kind of Bu	siness/Inc	Justry
121	Althin han a	de la	Elementary/Secondary (0-12) College	(1-4or 5+)	life. DO	O NOT use retir	red)		None		
	filed with Hygiena. ther than		11th 17. Fether's Neme (First, Middle, Last)			Homema	_	Name (First, Middle		-1	
ano	ntal h	Be	Lloyd Lipscomb					ry M. Au		е)	
Maryland	2 should be filed within end Mantal Hygiena. Is marked other than sumetic event, me Mantal Mantal event, me Mantal event, me Mantal event, me Mantal event, me Mantal event ev	2	19a. Informent's Name/Relationship (Type, Print)	197	h Mailing	Address (Stree		r Rurel Route Numb		State Zin	Code)
	nd 2 :		Henry R. Austin (B)					emphill,	-	3842	
ē,	gas 1 and 2 should be filed within 72 ho to f Health end Mental Hygiena. If Itam 27 is marked other than "natur or other traumatic event, Tra Med call		20e. Method of Disposition	20b. Pleca o	of Disposi	ition (Name of		Date	20c. Location -	City or To	wn, State
E	Pagas nent of h int: If its iry or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donetion 5 ☐ Other (Specify)	n State		Park		7/1/97	Rockv	ille	MD.
Baltimore,	- 555	l Y	21 Signature of Funeral Service Licensee		22.	Name and Add	ress of Facility				., 115
m	Depermine Deperm	<	there & h		SNO	OWDEN CKVILL	FUNERA	L HOME, 20850	P.A.		
			23a. Part1. Enter the disease, or complications that shock, or heert failure. List only one ceuse on	caused the deeth. Do	not enter	the mode of dy	ring, such as car		rrest,		Approximete
	Physician		STOCK, OF HEER LAWRE. LIST OF A DEUSE OF	each mie.						1	Intervel Between Onset end Deeth
	/Medical		Immediate Ceuse (Final disease or condition	NTRACRA	n, 4	e hen	nnond	ese.			2 days
	Examiner		resulting in deeth) a	Due to (or es e				0			
	pe ii	Examiner	b							ĺ	
_	certificate be assocuted rding physician and ise as the burial-transit	xan	Sequentially list conditions, if eny, leading to immediate	Due to (or es e	conseque	enca of):				1	
68760,	be a sician buris		cause. Enter Underlying Ceuse (Disease or injury thet initieted events								
687	tificate g phys as the	edic	resulting in death) Lest	Due to (or es e	conseque	ence of):					
×	eath certif attending for use a	Z	d								
. Bo	law requiras thet tha death ias been signed by the atter s 2 should be deteched for u	Physician/Medical	Pert II. Other significent conditions contributing to	death but not resulting i	In the und	teriving cause o	iven in Part i	23b. Dld	tohecco uee cor	atribute to	the ceuse of death?
P.0	thet tha de led by the a deteched t	hys	4	g		Jony ing duddo g	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				pably 4 □ Unknown
	as the igned I be det	by F	11 de la la la la		_						
Records,	v require been si should l	ted	Dedrites						en eutopsy ormed?	ave	ere eutopsy findings eileble prior to
e C	has be	pie	<u> </u>					_   '			mpletion of cause death?
<u> </u>	0 - 0	Completed	Cercbon Bala Au de	nt				10	Yes 2 No	1 🗆	Yes 2 Mo
Vital	iclan: Th certificate rector, par	Be	25. Was case referred to medical examiner?				26. Place of	Death (Check only	one)		
of	hys his	ို	1 ☐ Yes 2 ☐ No Hospitel: 1 ☐	Inpatient 2 ER/O		3LI DOA		ng Home 5 Resi			1)
	g fe	inol inol	- Careatoral Calcula		Time of Injury	28c. Inj		28d. Describe	how injury occurr	ed	
Sign	Attending or death. ector: After by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 280 Black	an of lainer. At home for	ot		Yes 2 No	29f Location /	Street end Numb	or or Pum	I Pouto Number
Division	il or Attanding P after death. Director: After t d in by the funera	Certification:	determined 200. Flat	ca of Injury - At home, fa ding, etc. (Specify)	arri, siree	et, rectory, office	9	City or To		si oi riaie	r Hoate Namber,
_	spital		29a. Certifier 1 Certifying Phyeician: To the	e best of my knowledge	e, deeth c	occurred et the	time, date end p	ace, end due to the	ceuse(s) end me	nner es st	eted.
	To the Hospital or Attandit within 24 hours after death.  To the Funeral Director: A completaly filled in by the fu	edical	(Check only 2 Madical Examiner: On the	besis of examination en nner stated.	nd/or inve	stigation, in my	opinion, death o	occurred et the time,	date end place, a	ind due to	the cause(s)
	To the To the Comp	×	290. Signature and title of certifier		-		nse number		29d. Date signed		
			Cycle Syl-			101	18726		June -	25, 1	997
			30. Name and eddress of person who completed cat  TRITITUR SULPENGOL	use of deeth (Item 23e)	(Type, Pr	rint)		/	0 .		
	2445		HATTUR SUIDENGOLI	1,40 9	715	MED	16AL CE	nt dr.	Macke	le,	MO 2085.
			the Page Clark March Day March	Dan Barrela Cina						/	

Registrar



State of Maryland / Department of Health and Mental Hygiene 97 21455

					Certifica	ate of	Death		Reg. No.	2	41400
Physic	ion	1. Decedent's Nama (First, Middla, La	st)					2. Data of Da Month		Vana	3. Tima of Death
/Medi		Reita L. Crow	e						9, 1997	Yaar	12:45 AM
Exami		4a. Fecility Nama (If not institution, giv	e streat and number)				4b. City, Town, or	Location of Deat	h 4c. Coun	ty of Deeth	
		Collingswood Nu:	rsing Home				Rockvil	le	Mont	gomer	У
Funeral Director		243-76-1036		(In yrs. last bii 39	thday) If Uni Month	der 1 Yaar hs Days		. (Month, Da	th ly, Year) 3, 1907	Cou	placa (Stata or Forei ntry) 1esee
and w		Usual Rasidance of Dacedant  10a. Stata 10b. County		10c. City, Tow	n or Location						10d. Insida City Limit
f ehc	ō	Maryland Montgome	2 2 2 2								1 ☐ Yas 2 🖾 N
the 1	Director	10e. Street and Number	ELY	NOLCII	Potoma	Zip Coda			10g. Citizan of	Mhat Cau	
with with	Ō	11220 Freas Drive			101.	208	70				
Pasth Pasth	era	11. Marital Status	12. Was Dacadant E	ver in U.S.	13 Was Da			Specify Vas or No	United	ce - Americ	
d within 72 hours efter death with the Manyland jiene. r than "natural", or Items 23a or 28a-f ehow the Medical Evantiner must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forcas? 1 ☐ Yas 27 No If Yas, Giva Year or Datas:			pecify Cul	Hispanic Origin? (a ban, Maxican, Pua Specify:	rto Rican, atc.)		ack, Whita,	atc.
72 h	Completed	15. Decedant's Ed (Specify only highest gra		16a.	Decedent's U	sual Occu	pation	arking.	16b. Kind of I	3usinass/In	dustry
ithin	npie	Elementary/Secondary (0-12)	Cotlege (1-4or 5+	-)	lifa. DO NOT	Tuse retire	during most of wo	nking			
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be filed tal Hygi d other svant, I	Be	17. Fathar's Nema (First, Middle, Last)					18. Mother's Ne	ema (First, Middla	, Maiden Suma	ma)	
Men Men arke	ဥ	Thadeus E. Lawso	on				Berti	e M. Thu	rman		
end end is m		19a. Informant's Name/Ralationship (	Type, Print)	196	. Malling Addre	ess (Straa	t and Numbar or F	lu <i>ral Rou</i> ta Numb	ar, City or Towi	n, Stata, Zip	Code)
and ealth n 27		Carole C. McCloud	l/Daughter				rive, No	rth Poto	mac, Ma	rylan	d 20878
permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if item 27 is marked other any injury or other traumatic event, once.		20a. Method of Disposition  1   Burial 2 □ Cramation 3 □  4 □ Donation 5 □ Othar (Specify		cematai	nooga M	orotharpk 1emor	July 3 ial Park		20c. Location Chattan Tennese	ooga, e	
Departition Depart		21. Signatura of Funeral Sarvica Licen	1/ 4	00348	Rockvi	llle	ass of FacilityRo Inc. 300 Maryland	O West M	ontgome	y Fun ry Av	eral Home enue,
Physician /Medical Examiner	9r	23a. Part1. Entar tha disaasa, or compand, or haart failure. List only immediata Causa (Final disaasa or condition rasulting in death)	a. Cardio	vascula	r Dise	ase		o or talphotory a			Approximata Intarval Batween Onsat and Death April 199 Present
xecuted and al-transit	Examiner	Sequentielly list conditions, if eny, laading to immediate ceuse. Enter Underlying Cause (Disaasa or injury	b	ua to (or as a d	consequance o	of):					
ntificate be executed ing physician and eas the bunal-transit	Medical	Cause (Disaasa or injury that initiated events rasulting in daath) Last		ue to (or as a o	onsequence o	f):					
death ce le attendi ed for use	Physician/		d								
s de a	sic	Part II. Other eignificant conditions co	ontributing to death but	not rasulting Ir	tha undarlying	g causa gi	van in Part I.	23b. Dld	tobacco usa c	ontribute to	the cause of death
res that the death cer signed by the attendir I be detached for use	þ							10	Yes <u>⊉(X</u> No	3 Pro	bably 4 Unknow
law requires that the as been signed by the e 2 should be detache	Completed							24a. Was parfo	an eutopsy rmed?	ev	ere autopsy findings eilabla prior to implation of ceusa daath?
The sate h	S							10	Yas XX No	10	☐ Yas ŽŽ.No
Physician: The li	Be	25. Was cesa rafarred to medical axeminar?					26. Placa of Da	ath (Check only o	ona)		
	2	1 ☐ Yas XXNo	Hospital: 1 Inpatiant	2 □ ER/Ou	tpatient 3 1	DOA Ot	har: 4X Nursing I	Homa 5□ Rasi	dance 6 DOt	har (Specif	<b>y</b> )
Attending Phor death.  ector: After this by the funeral		27. Manner of Death  1 Natural 5 Panding invastigation			ima of njury M	28c. Inju Wo 1		28d. Dascribe			
구름다	Certification:	3 Suicide 6 Could not be datarminad	building, atc.	(Spacify)				City or To	vn, Stata)		il Route Number,
Hosp 24 hor Fune Itely fi	edical	29a. Cartifiar 1 ☐ Cartifying Phy (Check only one)	valcian: To the bast of lnar: On the basis of and manner state	etion and	, death occurre	ed at tha ti on, In my o	ma, date and place opinion, death occ	e, and dua to tha urred at tha tima,	causa(s) and m date end place	annar as s and dua to	teted. o tha cause(s)
e i e g	2	29b. Signatura and titla of certifiar	11		2	29c. Lican	sa number		29d. Date sign	ed (Month,	Day, Year)
To the Hospital Within 24 hours To the Funeral I completely filled	-	Musen o	Sell.	Occ 1.	41	DD	6614		0/30	0/97	7
		Mynn 30. Neme end addrass of person who do	completed ceusa of dea	th (Item 23a) (	Type, Print)	00	66 M	HOREF	130	2/97	7

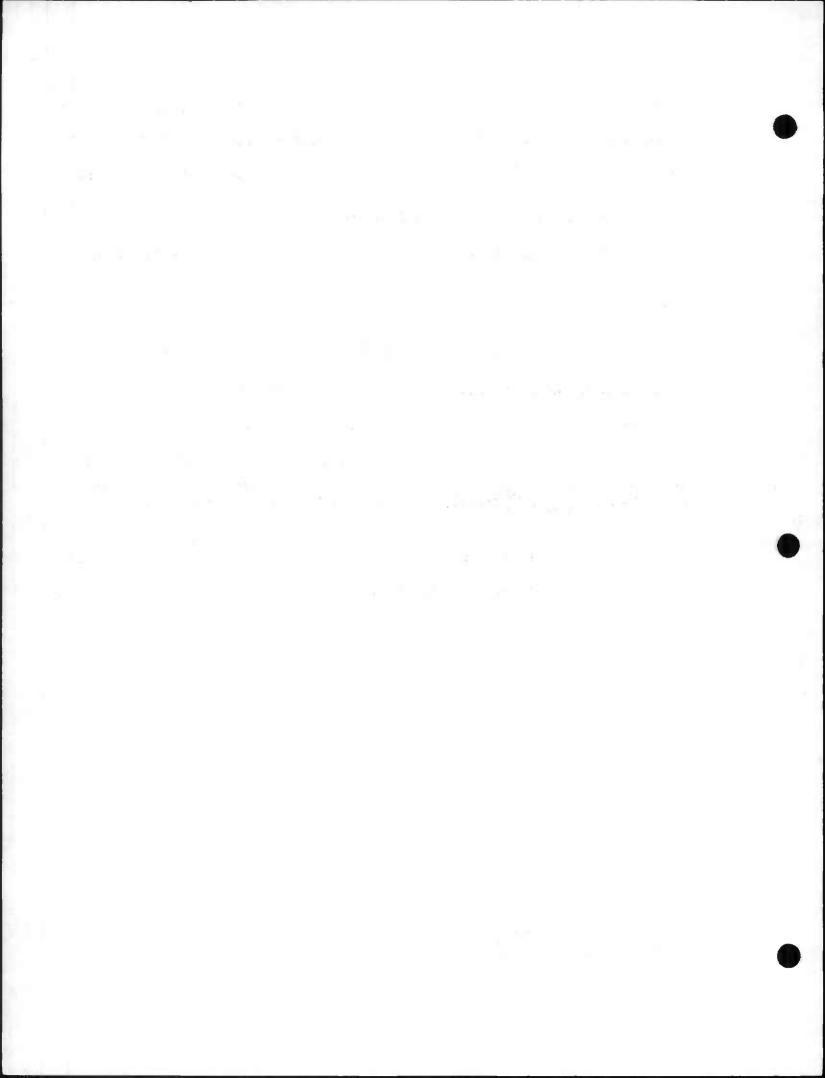


State of Maryland / Department of Health and Mental Hygiene

21456

						Ce	rtificate (	of Death		Reg. No.				
	Physic	an	1. Decedent's Neme (First, Mide	fle, Last)					2. Date of De	eth	Year	3. Time of Deeth		
	Physic /Medi		RIVY		CUTLI	ER			JUNE 3	0, 1997	1641	11:55AM		
A.	Exami	ner	4e. Fecility Neme (If not institution 1401 BLAIR M					4b. City, Town, of SILVER	or Location of Death SPRING		y of Deeth	MERY		
	Funeral Director		5. Social Security Number 040-22-7968	6. Sex 7 1 ☐ M 2 💢 F	'. Age (In yrs 90	last birthday, Yrs.		ear If Under 24 H ays Hours M		y, Year)	9. Birthp Cour	olece (State or Foreign htry) NY		
Т	pus *		Usual Rasidance of Decedent 10a. Stete 10b. Count	v	10c C	ity, Town or L	ocetion					Od Incide City Limits		
	Maryla f sho	0		GOMERY			SPRING				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No		
	28a	Director	10e. Street end Number				10f. Zip Cod	de		10g. Citizen of	Whet Cour	itry?		
	ath with		1401 BLAIR MI				209			UNITED	STAT	ES		
020	n 72 hours effer death with the Maryland "natural", or Itams 23a or 28a-f show solical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Ma  3 ☒ Widowed 4 □ Divorce	WVan Chia	es? No		Was Decedent If Yes, specify 0 1 ☐ Yes 2	of HispenIc Origin? Cuben, Mexicen, Pu No Specify:	(Specify Yes or No erto Rican, etc.)	Bia	ce - Americ ck, White, v: WHI	etc.		
Maryland 21215-0020	I within 72 liena. r than "nai	Completed	15. Deceda (Specify only high Elemantary/Secondary (0-12)	nt's Education est grade completed)  College (1-4	4or 5+)	(Give	dent's Usuel Od kind of work do DO NOT usa re	one during most of w	vorking	16b. Kind of B		fustry		
br	Hyg Hyg	BeC	17. Fether's Neme (First, Middle	, Last)		1		18. Mother's N	lame (First, Middle,					
ylaı	0 0 0 0 0	TOE	RABBI JOSEPH	NATHAN ROSE	ENBERG			MARION	SERLING					
Man	and and sem		19a. Informent's Neme/Reletion	ship (Type, Print)		19b. Meili	ing Address (Sti	reet and Number or	Rural Route Numbe	er, City or Town	State, Zip	Code)		
	s 1 and 2 of Haalth item 27 i		HERSCHEL CUTL  20e. Mathod of Disposition	ER / SON	20h		MARCL] osition (Name o	FF ROAD,	ROCKVILL			Chata		
Baltimore,			1 Buriel 2 ☐ Cremetion		tate	cemetery, cre	matory or other	place)		20c. Location				
	프 든 은 은		4 Donetion 5 Other (	·_ ·	BE I		OM CEME	IEKY idress of Facility	7/1/97	CAPITO	L HET	GHTS,MD		
B	Depa Impo any I		77-1	( 11		DA	ANZANSKY	Z-GOLDBÉR						
	Physician /Medical		23a. Part1. Enter the disease, c shock, or haart feilure. Lis	t only one cause on aed	ch lina.	th. Do not en	ter the mode of				AKILA	Approximate Intervel Batween Onset end Death		
1	Examiner	dissess or condition rasulting in deeth)  e. CEREBRAL VASCULAR ACCIDENT  Due to (or es e consequence of):												
	D 5	ner												
	and transi	Examiner	Sequentially list conditions,	б.	Dua to (	or es e conse	quence of):				-	YEARS		
60,	be axi ician a burial		Sequentially list conditions, if eny, laading to immediata ceuse. Entar Underlying Cause (Disease or injury	C										
Box 68760,	aath certificate be axecuted ettending physician and for use as the burial-transit	in/Medical	that initiated events resulting in death) Lest	d	Due to (d	or es a consec	quence of):				1			
	daath he etter ed for u	Physician/	Pert II. Other eignificent condit	ons contributing to dea	th but not res	ulting In the u	inderlying ceuse	given in Pert I.	23b. Dld 1	obacco use co	ntribute to	the cause of death?		
s, P.O	as thet the da igned by the e be deteched t	by Phy							10	Yes 2 No	3 Prot	bably 4 Unknown		
Vital Records,	aw requires been so	Completed								en eutopsy med?	COL	ere eutopsy findings eilebie prior to mpletion of cause daeth?		
a	The page								101	res 2 No	1 🗆	Yes 2 No		
	Physician: The this cartificate ral director, page	o Be	25. Was cese referred to madica axaminer?	Hospital				Other:	eath (Check only o					
o	Phys arthis eral d	-	1 ☐ Yas 2 No 27. Mannar of Death	28e. Data of (Month,		ER/Outpatie 28b. Time o		4 ☐ Nursing njury et Work?	Home 5 Resid			')		
Division	or Attending efter death. Director: After i in by the fune	catio	1 Neturel 5 Pandi 2 Accident invest 3 Suicide 6 Could	igation not be		Injury	М	1 Yes 2 No						
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	To the Hospital or Attanding is within 24 hours efter death.  To the Funeral Director: After completely filled in by the funer	edicai	29a. Certifiar t ☐ Certifyi (Check only one)	ng Physician: To the be Examiner: On the bes and manne	is of examina	owledge, deat ation and/or In	h occurred at th vestigetion, In n	e time, date end pla ny opinion, death oc	ca, and dua to tha courred et tha time,	cause(s) end m date end place,	enner as st end due to	eted. the ceusa(s)		
0		Σ	29b. Signature end title of certific	. W	/	- h	29c. Lic	ense number		29d. Date signe	d (Month,	Day, Year)		
	6		Juden	4/1/	rge		DO	7568		JUNE 3	0, 19	97		
			30. Nama and eddrass of persor											
	-		DR. FREDERICK	MEYERS, 244	0 M.	ST., N	N, #417	, WASHING	TON, D.C.	20037				

Registrar



				State of Ma	-	epartment of l Certificate of		na wentai n	ygiene 🧳	1 6	1401			
	Dhusiai	ion	1. Decedent's Name (First, Middle, Lo	est)				2. Date of D		Yeer	3. Time of Death			
	Physici /Medi		Wilfred J.	Coupal				June 2	7, 1997	1001	1:17 A.M.			
	Examir	ner	4e. Fecility Name (If not institution, gi					n, or Location of Dea						
	11.553		7216 Roanne Dr.				Oxon H		Princ	e Geo	rge's			
	Funeral Director			Sex 7. Agr	78 Yı	Months Devs		Min. (Month, E	lirth Dey, Year) 25, 1918	9. Birthp Coun Mass	place (State or Foreign htry) achusetts			
	Puel H		10a. Stete 10b. County		10c. City, Town	or Location				1	0d. Inside City Limits			
	Mary Fled	ţō	Maryland Prince	George's	Oxon	Hill					1□Yes 2□No			
	r 28s	<u>2</u>	10e. Street end Number			10f. Zip Code			10g. Citizen of V	Whet Cour	ntry?			
	th wit	al D	7216 Roanne Dr.			20745	j		U.S	. A.				
Maryland 21215-0020	s within 72 hours efter death with the Maryland liene. Than "natural", or flems 23a or 28s-f show the Medical Examiner must be notified at	by Funeral Director	11. Maritel Status  1 □ Never Married 2 ☐ Married  3 □ Widowed 4 □ Divorced	12. Wes Decedent I Armed Forces? 1& Yes 2 N If Yes, Give Yeer or Dates:	io	13. Was Decedent of If Yes, specify Cut		n? (Specify Yes or N Puarto Rican, etc.)		ce - Americ ck, White, c	etc.			
5-(	72 h	etec	15. Decedent's E (Specify only highest gr	ducation ede completed)	16a. D	Decadent's Usuel Occu Give kind of work done ifa. DO NOT use retire	pation during most o	of working 16b. Kind of Businass/Industry						
121	filed within Hygiene. ther than "	Completed	Elementary/Secondary (0-12)	Coltega (1-4or 5	+)		ed)		II C	NT				
2			17. Fether's Neme (First, Middle, Last	3		Military	to Mathada	a Nama /First Middle	U.S. Navy					
an	d ia o	Be	Frederick Coupal	*				cardia Fo		10)				
1	is 1 and 2 should of Health and Men item 27 is marks other traumatic	P	19a. Informant's Name/Relationship		10h A	Mailing Address (Stree				Ctate Zin	Codel			
	tra tra					16 Roanne					(2006)			
ē,	iges 1 end 2 it of Health If item 27 I or other tra		Rita M. Coupal/Wi 20a. Method of Disposition		20b. Placa of D	Disposition (Neme of cremetory or other ple	Dr. Ux	Date	20c. Location -		wn, State			
Baltimore,	permit. Pages Department of I Important: If ite any injury or or once.		1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ② Other (Speci	Removel from Stete  Lntombme		rrection C		6/30/97	Clinton	. Mar	vland			
ä	mit.		21. Signature of Funeral Service Lice				,							
m	Depariment Important Important Information		1 Horuse	HAROV.	Funeral H	ome Hill Ma	207	7.45						
1			23e. Pert1. Enter the diam se, or com shock, or haart failure. List only	plications that caused			. 207	Approximata Intervel Between						
	Physician		Shoot, of Haart lands. Clot only			1	Onset and Death							
	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)  e. Explanated Durker Zweets  Zweets											
		7	resulting in datatri)		e to (or es e co	nsequence of):								
	nsit	Examiner		b										
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	g phy es th		rasulting in death) Last		Dua to (or es e cor	isequerice (i):								
Box	death certi e ettending ed for use e	N/UE		d										
	the ett	sicia	Part II. Other eignificant conditions of	ontributing to death bu	t not resulting in ti	he underlying cause gi	ven in Pert I.	23b. Die	d tobacco use co	ntribute to	the cause of death?			
P.O.	± 60	Physician/M						18	Yes 2□ No	3 Prot	bably 4 Unknown			
ŝ	S 50	by						_						
0	v requires been sign should be	Completed						24a. We	s en eutopsy formed?	eve	ere eutopsy findings			
Sec	aw 2 s	nple								of c	mpletion of cause deeth?			
<u>e</u>	t eee							1	Yes 2 No	1 🗆	Yes 2□ No			
Z.	ysician: The is certificete director, par	Be	25. Wes case referred to medical exeminer?	Hospitel:		0		f Deeth (Check only	one)		11.			
of Vital Records,	2 00	. To	1 ☐ Yes No 27. Menger of Death	1 ☐ Inpatier	1	atient 3L DOA		ing Home 5 Res		er (Spacify	Home			
	After fune	tion	1 Matural 5 ☐ Pending	(Month, Dey	Year) 200. Inju	ıry Wo	rk? ]Yes 2 ☐ No		how injury occur	ea				
Division	Attending or deeth. ector: Afte by the fune	fica	3 ☐ Suicide 6 ☐ Could not b	e One Diese of Injur	rv - At home, farm	, street, factory, offica	7,00 2010		(Street end Numb	er or Rum	I Route Number			
S	or efter	Certification:	4 Homicide	building, atc	(Specify)	, ones, lastery, since			own, Stata)	0, 0, 1,0,0				
	To the Mospital or Attending Ph within 24 hours efter deeth. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Ph	yelcian: To tha bast o	my knowledge, d	laath occurred et the ti	ma, data and p	place, and due to the	e cause(s) and ma	inner as st	eted.			
	n 24 n 24 ne Fu	edicai	(Check only one) 2 Medical Exar	niner: On the basis of end manner ste	examination end/o	or investigetion, in my	opinion, deeth	occurred et the time	, date end plece,	and due to	the ceusa(s)			
	To t To th	Σ	29b. Signature end title of certifier	^	. 11	29c. Licens	se number		29d. Date signa	d (Month, E	Day, Year)			
1			W Vom	VNM2	> All	evelue.	D-2	4535	K	125	3197			
(	81		30. Neme and eddress of person who Laxmi N. Berwa			pe, Print) Branch Ave	#C101	Clinton	Md 20	735				
	Sta	te	31. Dete filed (Month, Dey, Yeer)	•	r's Signeture		11 OTOT	, OLLIICOII	, 114. 20	, 55				
	Registra	ar	JUN 3 0 199	July do	udlartan	a.15								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Month Year John Robert Colister, Sr. 23 June 1997 2:52 AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth
Prince George's 4b. City. Town, or Location of Deeth **Examiner** Doctor's Community Hospital Lanham 7. Age (In yrs. last birthday). If Under 1 Year | ff Under 24 Hrs. | 8. Dete of Birth (Months, Day, Year) 9. Birthplace (State or Foreign **Funeral** 213-12-5124 1**X**(**X**) 2□ F Ohio March 1,1920 Director Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumetic event, the Medical Examiner namt be notified at Maryland Prince George's College Park XX Yes 2 No Director 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 20740 United States 5904 Bryn Mawr Road Items 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? XXIYes 2 □ No If Yes, Give Year or Detes: WWII 14. Race - American Indian, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married "natural", or White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Department of Health and Mentel Hygiene. Important: If itam 27 is marked other than "n, any Injury or other traumatic account. College (1-4or 5+) Elementary/Secondary (0-12) Police Officer Maryland State Police 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Gertrude C. Slavin Robert Earl Colister 19e. informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Ruth Virginia Colister (wife) same as #10 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Buriai 2 Cremation 3 Removel from State Arlington National Cemetery 6/27/1997 Arlington, Virginia 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Donald V. Bordwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland20705 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Electromechanical Dissociation 30 minter Examiner Examiner attending physician and for use es the burial-transit that the daath certificete be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Records, P.O. Box 68760, Physician/Medical the Part II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Pert f. 23b. Dfd tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed l þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed page 2 s 1 Yes 2 No 1 TYes 2 □ No certificate Division of Vital Hospital or Attanding Physician: 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28b. Time of 28c. Injury et Work? Medicai Certification: 28d. Describe how injury occurred Aftar 5 Pending investigation 1 Natural To the Hospital or Attandir within 24 hours after death.
To the Funeral Director: Al complately filled in by the fu 1 Yes 2 XNo 2 Accident 3 Suicide 6 Could not be determined Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

31. Dete filed (Month, Day, Year) JUN 30 1997

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

29b. Signature end title of certifier



Sartifying Physiofan: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end manner es stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

29d. Date signed (Month, Day, Yeer)

AND THE PROPERTY OF THE PARTY.

211.50 State of Maryland / Department of Health and Mental Hygiene

					il ylaila / i		icate of		rviernar i ryg	leg. No.	)	41433
	Dhusia	:	Decedent's Name (First, Middle, Last)		0				2. Dete of Dee	th	V	3. Time of Death
4	Physic /Medi		ERNEST	W.	CRA	7W,	FOR	D	-Month JUNE	27 - A	1997	10.48 as
	Exami		4e. Fecility Neme (If not institution, give st	reet and number)				4b. City, Town, or	Location of Deeth	4c. Count	of Deeth	
1				1/AND	Hosp			Chin	1702	Dn	NCE	(DEDALES
۱	,Funeral Director		5. Social Security Number 6. Sex 409–38–7743		(In yrs. last bii <b>70</b>		Under 1 Year onths Days	Hours Min			9. Birthpl Count A1	ace (State or Foreign try) Coa, TN
	pu »		Usual Residence of Decedent  10a. Stete 10b. County		10c. City, Tow	m au Lanati						
	within 72 hours efter death with the Maryland ene. than 'neturel', or frems 23e or 28e-f show he Medical Examiner court be notified a	Director	Maryland Prince Ge	_	Clint		ori				10	od. Inside City Limits 1XXes 2 □ No
	or 28	- ic	10e. Street end Number			1	0f. Zip Code		1	0g. Citizen of	Whet Count	try?
	23a	<u>e</u>	11121 Piscataway R	load			207	35		USA		
	er de	Funeral	11. Marital Status	. Was Decedent E Armed Forces?	ver in U,S.	13. Was	Decedent of H s, specify Cubi	Ilspenic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		e - America	
20	s eff	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give	1946		Yes 2 No	Specify:		Specif	y:	
21215-0020	72 hours eff "natural", or		15. Decedent's Educa	Yeer or Detes:		Decedent	e Heural Occur	action			BLA	
215	be filed within 72 ho ttal Hygiene. d other than "natur event, the Medical	Completed	(Specify only highest grade of	completed)	100.	(Give kind life. DO f	s Osuel Occup of work done VOT use retired	etion during most of wo d)	rking	16b. Kind of B	usiness/ind	ustry
212	e filed within Il Hygiene. other than	E	Elementary/Secondary (0-12)	College (1-4or 5+	-)	Uti	lity S	pecalist	]	Philade	1phia	Gas Work
	il Hygie other	Be C	17. Fether's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle, i	Maiden Surnar	10)	
Maryland		TOE	Robert Crawford					Cat	herine Tl	norpe		
an	and and s m		19a. informent's Neme/Relationship (Type	, Print)	19b	. Meiling A	ddress (Street		ural Route Number		State, Zip	Code)
			Agnes Crawford/wife					way Road	Clinton	n,Md. 2	0735	
Baltimore	20 天平 1		20e. Method of Disposition  1  ■ Buriel 2 □ Cremetion 3 □ Rer	and from Chata	20b. Place of cemeter	f Dispositiony, cremato	n (Name of ry or other plac	ce)	Date	20c. Location	City or Tov	vn, Stete
Ĕ	artment or pertant: If injury or		4 □ Donetion 5 □ Other (Specify)	novel from State			morial		07/02/97	Landov	ar Md	
att	mit.		21. Signature of Funeral Service Licansee			22. Na	me end Addre	ss of Fecility			er sind	
ш	205 # 8		116:16	00					neral Hord, S.E. Wa		2002	0
			23a. Part1. Enter the descent of complica shock, or heert fail to List only one	tions thet caused t	he death. Do r	not enter th	e mode of dyir	ng, such es cardie	c or respiretory err	est,		Approximete
Я	Physician		onoun, or nount langue. Classonly one	Cause on each line								Intervel Between Onset end Deeth
ч	/Medical Examiner		Immediate Cause (Final disease or condition	CAR	ENON	nA .	LUNG					2431725
П	LAUIIIIII	_	resulting in death) e	0	ue to (or es e	consequenc	ce of):					
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,00	ifficete be executed g physician end es the bunal-transit	Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events	D	ue to (or es e o	consequenc	ca of):				1	
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Division of Vital Records,	8 5 8	d by								orazulo —	041 144	P - P
Ö	v requir been s should	Completed							24a. Wes e perforr		eve	e eutopsy findings lable prior to apletion of cause
360	2 55 0	E									of d	eeth?
a	E seg								1 □ Ye	s 2 No	1 🗆	Yes 2□ No
Z.	Physician: The this certificate ral director, pag	Be	25. Wes case referred to medical examiner?	pitel: 🇘			Oth		ath (Check only on	θ)		
o	Q 50 X	<u>۲</u>	1 162 2 NO	1 Inpatient 28e. Dete of Injury		tpetient 3	DOA Oth	4 Li Nursing r	lome 5 ☐ Reside			
on	dlng h. After fune	Certification:	Naturel 5 ☐ Pending	(Month, Day		njury N	28c. Injun Work	k? Yes 2 □ No	28d. Describe ho	w injury occur	.60	
S	or Attending effer death. Director: After d in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Plece of Injury	v - At home far			165 2 [] 140	28f. Location (St	reet and Numb	or or Pural	Pouto Number
2	efter Direct	ert	4 ☐ Homicide determined	building, etc.	(Specify)	ini, 311 <del>00</del> 1, 1	ectory, omca		City or Town	, State)	er or riorar	noute Number,
	spita nours noral		29e. Certifier Certifying Phyelci	en: To the best of	my knowledge	deeth occi	urred at the tim	ne dete end place	and due to the or	uso(s) and me	anar an da	tod
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Examiner one)	On the besis of e	xeminetion end	d/or Investig	gation, in my or	pinion, deeth occu	rred et the time, da	ite end place,	end due to t	the cause(s)
	Nithir Comp	ž	29b. Signature and title of certifier	1)1	-		29c. License	e number	25	d. Date signe	d (Month, D	ay, Year)
		)	1 / Sweet To	ten for	20		D3	0125		6. 27.	100	
	111	/	30. Name and address of person who comp	leted cause of dee	th (Item 23a) (	Type Print		0133		6.27.	1771	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month June **Physician** 7:00 AM Κ. Caboga Violet /Medical 4b. City, Town, or Location of Deeth 4a. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Lanham Prince Georges Doctors Community Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Deys Hours Min. (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Deys Hours 1 M 287¥ 575 44 8669 Yrs. 55 Director May 5, 1942 Hawaii Usuat Residenca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f shon i notified at X⊠Yes 2□No Prince George's Bowie Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? than "natural", or items 23s or the Medical Examiner must be United States by Funeral 15019 Nighthawk Lane 20716 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Yeer or Dates: Was Decedent of Hispenic OrigIn? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Executive Assistant Beverage Distributor merked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 2 should be fill and Mental H Be 20 Kiyoshi Kawasaki Ishiko Oshikata 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Pages 1 and 2 is ment of Health an item 27 i 15019 Nighthawk Lane Bowie Maryland Ann F. Kawasaki Sister 20716 20b. Pleca of Disposition (Neme of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete Department of Important: If it any injury or o 1 ☐ Burial 2XX remetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory June 28, 1997 Alexandria Virginia 22. Name end Address of Fecility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715 Approximate Intervel Between Onset end Deeth Physician /Medical Immediate Ceuse (Final diseese or condition resulting in death) Examiner enebno Viscolor Physician/Medical Examiner sician and burial-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury Box 68760, physician s the buria thet initiated events resulting in deeth) Lest Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Constid Endontenector; 1 ☐ Yes 2 No 3 Probably 4 Unknown þ THNOMESCIS left common 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Be Completed 24a. Wes en eutopsy 1 Yes 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 28 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To After this funeral 28c. Injury et Work? 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 5 Pending investigation Naturel 1 ☐ Yes 2 ☐ No 24 hours efter death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) pletely filled in by 4 Homicide 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner steted. within a To the 29b. Signature and title of cedifier 29d. Date signed (Month, Dey, Yeer) 29c. License number 30. Neme end address of person wno complet d ceuse of deeth (Item 23e) (Type, Print) LU 7223 Hanven Partury Gnerobelt Mid 20770 BNIAN 5 31. Date filed (Month, Day, Yeer) . Registrer's Signeture

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**DHMH 16 Rev 6/95** 

Registrar

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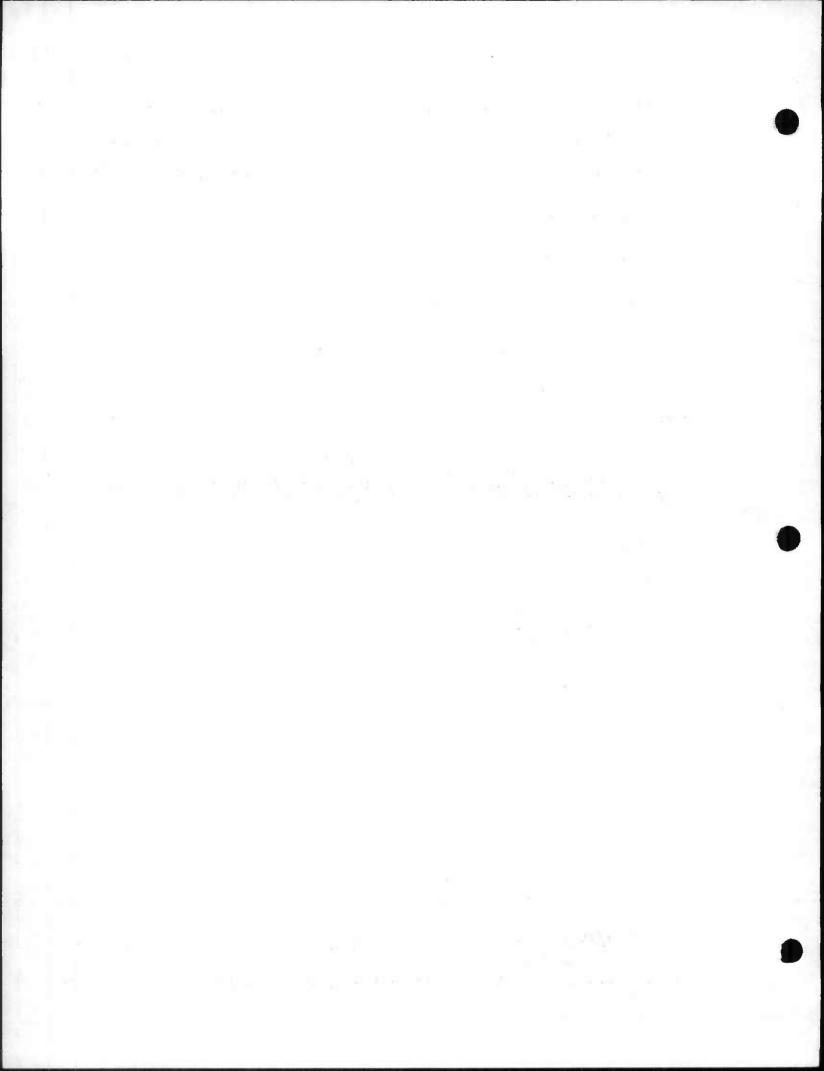
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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene 97 2 1461

1. Decedent's Name (First, Middle) Law John Francis Dyer, Jr.  46. Feelilly Name (First institution, plus stores and number)  78.05 Fullbright Court						Cert	tificate o	f Death	7		Reg. No.		
Modical Examinary  Family Internal Print Authors (print where outlands)  For Examinary  For Hard Status  100 Court  100 States and Print (Court  100 States and P	Dhusis		1. Decedent's Neme (First, Middle,	Last)							eeth	V	3. Time of D
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John F. Dyer, Sr.  Josephine S. Colgan  190. Melling Address (Street and Number or Rural Route Number, City or Town, Stets, Zp Code)  Audrey L. Dyer / wife  20a. Method of Disposition  1	show				10c. City, To	wn or Loca	ation					1	0d. Inside City
John F. Dyer, Sr.  Josephine S. Colgan  190. Informent's NameRelationship (Type, Print)  Audrey L. Dyer / wife  20a. Method of Disposition  1	1-8	cto	Maryland Montg	omery	Bet	hesda	а						1 ☐ Yes 2
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22. Name and Address of Feolilly Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase 7557 Wisconsin Avenue, Bethesda, Maryland 20814–3501  23e. Part I. Enter the chase, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, interest entered to mediate Cause (Final resulting in deeth)  25e. Part II. Enter the chase, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, interest entered to mediate Cause (Final resulting in deeth)  25e. Due to (or es e consequence of):  Ventricular Arrhythmia  Due to (or es e consequence of):  Ventricular Arrhythmia  Due to (or es e consequence of):  Ventricular Arrhythmia  Due to (or es e consequence of):  Per III. Other significant conditione contributing to deeth but not resulting in the underlying cause given in Per I.  1   Yes   2\times   No   3   Probably   4    24e. Was an autopsy performed?  25e. Wes sees referred to medice!  27e. Menacer of Deeth (Check only completion of of deeth?)  27e. Menacer of Deeth (Check only completion of of deeth?)  28e. Deet of Injury and Control of the completion of	of it H				20b. Plece	of Disposi	ition (Name of						wn, State
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Julie 30, 1997			SMINW	7/			D25	818			June	30 1	997
30. Name and address of person with completed cause of death (Item 23e) (Type, Print)		-	30 Name and address of parents and	completed as	noth /ltow co.	(Turn = =					June	50, 1	

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 11:07 PM June Μ. Doolittle 28 1997 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street and number) 4c. County of Death Holy Cross Hospital Silver Spring Montgomery | SIIVEL - |
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | 9. Birthplece (Stare or 10 to 7. Age (In yrs. last birthday) 1 M 2 XF Yrs 88 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 437 Northwest Drive 20901 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 Yes X□ No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Executive Assistant Hote1 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Willard E. Owens Anne Carrico 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond E. Doolittle / Son 16909 George Washington Drive, Rockville, MD 20853 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 7/2/97 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify)

11800 New Hampshire Avenue

Silver Spring, Maryland

cations that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest,

?7 is merked other than "natural", or items 23a or 28a-f show treumetic event, the Madical Examinar must be notified at permit. Pages 1 and 2 should be filed within 72 hours effer bepertment of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "natural". or least in jury or other traumain. Baltimore, Maryland 21215-0020

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

238

Director

Funeral

by

Completed

the Merylend

Viola

5. Sociel Security Number

577-03-7828

10e. Street and Number

10a. State

Usual Residence of Decedent

Elementary/Secondary (0-12)

20a. Method of Disposition

10b. County

**Physician** /Medical Examiner

physicien end s the buriel-transit

the 6

page

certificete

After

To the Hospital or Attending PP within 24 hours effer death.
To the Funeral Director: After the completely filled in by the funeral

8

Box 68760,

P.O.

Records,

of Vital

Division

Certification:

	disease or condition resulting in death)
by Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
	Part II. Other elgnificant conditions  Metastatus
I o Be Completed	25. Was case reterred to medical examiner?
Ë	27. Manger of Death

Natural

∠ □ Accident

3 Suicide

4 Homicide

iditions, mediate rlying injury

23a. Part1. Enter the disease, or common shock, or heart failure. List only one

я	Cardiac 17me
	Due to (or as a consequence of):
b	Coronary Hilley
D.	• Due to (or as a consequence ut):
C.	Artenoselerous
	Due to (or es e consequenca of):

usor

cant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

22. Name and Address of Facility Hines-Rinaldi Funeral Home

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy tindings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed?

Approximete Interval Between Onset end Deeth

1 Yes 2 No

	26. Place of Death (Check only one)										
He	ospital: 1 npatient 2	☐ ER/Outpatient	3□ DOA	Other: 4 Nursing I	Home 5 Residence	6 □Other (Specify)					
	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c	. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred					
•	28e. Place of Injury - At building, etc. (Spec	home, farm, stree cify)	t, factory, o	offica	28f. Location (Street e City or Town, Sta	end Number or Rural Route Number, te)					

29a. Certifier (Check only one)		xamination and/or In		and due to the cause(s) and manner as stated. ed at the time, date and placa, and due to the cau	se(s)
20h C:	 A		On Henry	20d Date street (Month Day Vos	1

5 Pending investigation

6 Could not be determined

JUL 01

MD000025765D.4.

30. Name and address of person who completed hause of death (Item 23a) (Type, Print)

CHASE, Md. 20815 CHEUY 530 Wisconsin 32. Registrar's Signature

Fund Javidson-Randelle

State Registrar

Medical

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 0.7

			State of Maryland / Dep	ertificate of		Reg.	- 1	214	63			
	Physici /Medi		1. Decedant's Neme (First, Middle, Last) Franzetta R.	De Goo	ruec 1	Dete of Deeth	-	3. Time of 22				
	Examir		4a. Facility Name (If not institution, give street end number)	•	4b. City, Town, or Location	n of Deeth	4c. County of	Death				
			Wilson Health Care Center	1 10 11 1 1 1 1	Gaithersburg			gomery				
050	Funeral Director		5. Sociel Security Number  577-28-1426  Usual Rasidance of Decedent	Months Days	Hours Min //	pete of Birth Wonth, Dey, Ye rch 8, 1	913 U	Birthplaca (Stefe Country) tah	or Foreign			
	nyland how		10e. Stete 10b. County 10c. City, Town or	Location			10d. Inside City Limits					
	Ba-fs	cto	Maryland Montgomery Bethesda				1 🗌 Yes	s 2 No				
	# 22	Director	10e. Street end Number	10f. Zip Code			Citizen of Who					
	sath v	erai	7111 Thomas Branch Drive	20817	Barrela Orlaino (Orranita)		ited St					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hyglena. Important if item 27 is marked other than "natural", or items 23e or 28e-f show many injury or other traumatic event, the Medical Exercine roust be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ₺ Widowed 4 □ Divorced  12. Wes Decadant Evar In U,S. Armed Forces?  1 □ Yes 2 ₺ No If Yes, Giva Year or Detes:	If Yes, specify Cube  1 ☐ Yes 2 ☒ No	dispanic Origin? (Specify en, Mexican, Puerto Rican Specify:	ras or No- n, etc.)		American Indian, Whita, etc.				
9	2 hou	ted	15 Decedent's Education 18e Dec	cedent's Usuet Occup	pation	16b	White 16b. Kind of Businass/Industry					
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and	d 2 should be filed within th and Mantal Hygiena. I is marked other than "fraumatic event, the Mas	Be	17. Fathar's Name (First, Middle, Last)		18. Mothar's Name (First	st, Middle, Meid	den Sumama)					
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re,	f Haa f Haa tam			sposition (Nama of cramatory or other pled								
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Baltimore, Maryland 21215-0020	Departm Departm Importa any inju		4 Donetion 5 Other (Specify) Arlington National Cemetery 7/8/1997 Arlington, VA  21. Signatura of Funeral Sarvice Licensee 22. Name and Addrass of Facility DeVol Funeral Home									
Ö	80 E 8		Michael D. Abbons 10 East Deer Park Drive Gaithersburg, MD 20877									
			23a. Pert1, Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest,  Approximate									
	Physician /Medicai		Immediate Cause (Final diseases or condition resulting in death)  5 years +									
	Examiner		resulting in deeth)  Due to (or es e consequence of):									
	Si g	iner	h									
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P. O.	The law requires that the death certificate be assocuted ta has been signed by the attending physician and page 2 should be detached for use as the bunal-transit				1 🗆 Yes	2 No 3	☐ Probably 4 ☐ Unknown					
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Vita	iclan: The cartificata rector, pag	Be Co	25. Wes case referred to medical		26. Place of Deeth (Ch		2,200	10100 25	Arro			
	nysici nis ca I direc	To	exeminer?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	tient 3 DOA Oth		g Homa 5 ☐ Residence 6 ☐ Other (Specify)						
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	5	4	Mars n	1D 0	1231	Ju	ly 1	1997				
			30. Name end address of person who complated causa of death (Item 23e) (Type	e, Print)	C -41 -	,						
	-0		31. Dete filed (Month, Lenver) 9 100 132. Register's Signature	hes Ave	Gaitherst	burg.	MD	20877				
	Sta Registr		31. Dete filed (Month, Her Pearl 3 1997) 32. Registrar Signature	- Brine								

DHMH 16 Rav 6/95

State of Maryland / Department of Health and Mental Hygiene 97

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	Dhamis		1. Decedent's Neme (First, Middle, L	ast)							2. Dete of D Month	eeth Dey	Voor	3. Time of	Deelh			
	Physici /Medi		DUKNELL DAVIS									JUNE 26 Dey 199		5:20	pm			
P	Examir		As Facility Name (Mant institution of a street and a section)								y of Deeth	ORGE 'S						
-	Francis	7		Sex,	7. Age (In yrs.	last birthday)	If Und	ler 1 Yeer										
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	Pwo #		10a. Stete 10b. County		10c. Ci	ity, Town or Lo	cation						1	Od. Inside Cit	y Limits			
21215-0020	Sa-f sh	Funeral Director	Maryland Prince George's Fort Washington										1 🗆 Yes	2 🖔 No				
	it t	급	10e. Street end Number 10f. Zip Code									10g. Citizen of		try?				
	ath v	Ta .	900 Lira Drive					0744			U.S.A.							
	er de	nue	11. Meritel Status	Armed Fo		J,S. 13.	Wes Dec If Yes, sp	edent of F becify Cubi	łispanic Or en, Mexica	igin? (Spo n, Puerto	ecify Yes or No- Pican, etc.) 14. Race - American Indien, Bleck, White, etc.							
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ш	Physician		George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md.20745															
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	0	Σ	29b. Signeture end title of certifier					9c. Licens					ed (Month,	Dey, Year)				
	1	30. Name and address of person who completed cause of death (Item 23e) (Type, Print)  Ke 1 th Ban to, wo 1/70/ Living to RI #								>	101	27/	97					
	111		30. Neme end eddress of person who	completed caus	e of deeth (Iter	n 23e) (Type.	Print)					0/0	-11					
	(14)		Keltz Banto		11	20/ 4	-10	ic ske	01/	2/ 1	# 300	Forth	Wark .	Jan M	2			
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Physic /Med		MILLIE						2. Data of De Month June	Day 25,	Yeer 1997 10:42 P.1	
Example Example Funera	P	4a. Facility Name (If not institution, given PRINCE GEORGES  5. Social Sacurity Number  6. S	S HOSPITAL	CENTE	t birthday) If	Undar 1 Yaar onths Deys	Cheve	s. 8. Date of Bir	Princ	of Death  Ce George's  9. Birthplaca (State or Foraign Country)	
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r 28a-f aho	rector	Maryland Prince G			Chever				10g. Citizen of	1⊠ Yes 2□ No	
aryland 21215-0020 should be filed within 72 hours after death with the Maryland and Mental hygiane. I marked other than "natural", or items 23s or 23s-f ahow urnatic event, the Modical Examinat must be notified at	Funeral Director	2900 Mercy Lane		Vas Dacedent Ever in U.S. 13. Was Decedent of Hispanic Origin?			(Specify Yas or No	United	d States De - American Indien, Ck, White, etc.		
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and 21215-0020 be filed within 72 hours af that Hygiene. dother than "natural", or event, the Madical Exam	Completed	15. Decedent's Ed (Specify only highest gre Elementery/Secondary (0-12) 1 2	College (1-4or	life DO NOT use retired)			orking 16b. Kind ot B		Business/Industry		
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C C 0 0 0		19a. Intorment's Name/Relationship ( Delia M. Campbel  20e. Method of Disposition		d	616 Ri	tchie	and Number or i Avenue,	Silver S	Spring,	MD 20910	
Trie Pa		1 ☑ Buriel 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specification 2). Signature of Funeral Service Licer	y)		ses Ce	n (Neme of ry or other plea metery me and Addra:		7/2/97	Lothian	City or Town, State	
Balt permit. Departin Importa any inju		23c and Emer the disease, or composite or heart failure. List only	11	TIT.	CTE	MADT TI	MEDAT L	OME, Inc	Washingt	on, D. C.	
Physician /Medical		Immediate Ceuse (Final disease or condition resulting in death)	Se	na. 2psi						Approximate Interval Between Onset end Deeth	
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I Records, P.O. Box 68760, The law requires that the death certificata be asscuted at the been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	Sequentially list conditions, if any, leading to Immadiate ceuse. Enter Underlying Ceuse (Disease or Injury that Initieted events rasulting in deeth) Last	c. Aceri	Due to (or es			24 Hz				
Box 6 eath certific attending p	Physician/Me	L	d								
cords, P.O. requires that the deben signed by the should be detached	by Physi	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert  CV A. DYSDNag 9.						23b. Did	1./	ntribute to the cause of death?  3 Probably 4 Unknown	
Records e law require hes been sig	Completed t	Decul M.I.	chro	cers		0			en eutopsy ermed?	24b. Were eutopsy tindings eveileble prior to completion of ceuse of deeth?	
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Phys arthis araid	ation: To	1 ☐ Yes 2 ☐ Hospital: ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA						## 4 Nursing Home 5 Residence 6 Other (Specify)  ## 28d. Describe how injury occurred  ## 28d. Describe how injury occurred  ## 28d. Describe how injury occurred			
Division  To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After complately filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ury - At home c. (Specify)	, term, street, t	actory, office		28t. Location ( City or To		per or Rurel Route Number,	
the Hospi hin 24 hou the Funer nplataly fil	Medical	one) 2 Medical Exam	ysician: To the best of iner: On the bests of end menner sta	examinetion	dge, deeth occ end/or Investig	gation, in my or	olnion, deeth occ	curred at the time,	dete end place,	end due to the ceuse(s)	
2 1 2 3		29b. Signatura and title of certitian	6. M.	Q.		29c. License	2580.		6-26	d (Month, Dey, Yeer)	
U		30. Margine end eddress of person who of S. DUTCA A 31. Date tiled (Month, Dey, Year)	MD. 563	eath (Item 23) 32 An er's Signeture	e) (Type, Print	POUS	Ro &	+13 B	MO 2	5-97. N18URG	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Month Yaar 45PM PEARL M. DODGE JUNG 1997 /Medical 4a. Facility Nama (If not Institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Daath Examiner PRINCE GEORGES HOSPITAL CENTER CHEVERLY PRINCE GEORGES If Undar 1 Yaar If Undar 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthpleca (Stata or Foraign Country) Funeral Days 1□ M 20XF Yrs. Director 579-28-7095 96 JUNE 28, 1900 VIRGINIA Usual Rasidance of Dacadant the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryler Department of Health and Mental Hygiene. Important: If item 27 is merked other than "naturel; or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinating mental per notified as 1 X Yas 2 □ No Director MARYLAND PRINCE GEORGES BRENTWOOD 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3603 43RD AVENUE Funeral 20722 UNITED STATES 12. Was Decadant Evar in U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 1 ☐ Navar Marriad 2 ☐ Marriad Saltimore, Maryland 21215-0020 1 ☐ Yas 2 💢 No Spacify: þ Specify. 3 XWidowad 4 ☐ Divorced WHITE Completed 15. Decedant's Education (Spacify only highast grada completed) 16a. Dacedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 CLERK RETAIL 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be 2 TURNER MADISON DOLLY WEEKS 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code) JAMES F. RIDDLE, SON 5325 TAYLOR ROAD, RIVERDALE, MARYLAND 20737 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) Data 20c. Location - City or Town, Stata 1 XBuriai 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) FORT LINCOLN CEMETERY 7/1/97 BRENTWOOD, MARYLAND 21. Signatura of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility FORT LINCOLN FUNERAL HOME 23a. Part 1. Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. 3401 BLADENSBURG RD., BRENTWOOD, MD 20722 Approximata Intarval Batween Onsat and Deeth **Physician** Immediata Causa (Final disaasa or condition resulting in daeth) /Medical STroke Examiner Dua to (or as a consequence of): Physician/Medical Examiner chemi went The law requires that the death certificate be executed the burial-transit Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or Injury that initiated avents rasulting in death) Last Dua to (or as a consaquanca of): Box 68760, physician Dua to (or as a consequanca of) for use P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 90 Completed 24a. Was an autopsy 24b. Wara autopsy findings available prior to completion of cause of death? this certificate has 2 NO 1 ☐ Yas 1 ☐ Yes 2 ☐ No Physician: Be 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Yas 2 No Certification: To 18 Inpatiant 2 ER/Outpatient 3 DOA funeral 27. Mannar of Death 28a. Deta of Injury (Month, Day Year) 28d. Dascribe how injury occurred After t Attending 1 Naturel 5 Pending invastigation Hospital or Attendit 24 hours after deeth. Funeral Director: A etely filled in by the fu deeth. 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Suicida Placa of Injury - At homa, farm, streat, factory, offica building, etc. (Specify) Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 24 hours edical 29a. Cartifiar Certifying Physician: To the bast of my knowledge, daath occurred at the time, data and placa, and due to tha causa(s) and mannar as statad.

Madical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, deta end placa, and due to the causa(s) and mannar steted. To the Hosp within 24 ho To the Fune completely f (Check only one) Σ 29b. Signature and title of pertition 29c. Licansa number 29d. Data signed (Month, Day, Year) 01989 30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) Rd Riverdile mo 4404 8 han B 31. Data filed (Month, Day, Year) 32 Ragistrar's Signature State

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Registrar

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						Certificate o	f Death		Reg. No.	/ fun i	401	
	Physic	ion	1. Decedent's Name (First, Middle, La	ist)				2. Dete of Dee Month	eth Dey	3. Tir	m= if C==th	
	Pnysic /Medi		JAMES DAVIS					JUNE		7.45	AM	
	Exami		4a. Fecility Neme (If not institution, give		•		4b. City, Town, or Lo	cation of Deeth	4c. County	of Deeth		
			5638 EMERSON ST.				BLADENSBUR			GEORGES	3	
	Funeral Director			Sex. 7. A 1 □ M 2 □ F	ige (In yrs. lest bi 50	rthday) If Under 1 Yes Months Dey		8. Dete of Birt Month, Dej JUNE 2,	h, Year) 47	9. Birthplece (S Country) WASHINGT	tete or Foreign ΓΟΝ, D.(	
	land w		10a. Stete 10b. County		10c. City, Tov	n or Location				10d. Insi	ide City Limits	
	Mery	ţ	MARYLAND PRINCE GEORGES BLADENSBURG							籽	Yes 2□No	
Maryland 21215-0020	3a or 28a	Funeral Director	10e. Street end Number 5638 EMERSON ST.	APT. B4		10f. Zip Code	20784		10g. Citizen of V	Vhet Country?	nerica	
	d 2 should be filed within 72 hours efter deeth with the Meryland thend Mentel Hygiena. T is marked other than "naturel", or items 23a or 28a-f show treamatic event, the Medical Exercites must be notified at	by	11. Maritel Stetus  Never Married 2 Married  3 Widowed 4 Divorced	12. Wes Deceder Armed Forces 1  Yes 2  If Yes, Give Yeer or Detes	No	13. Wes Decedent of It Yes, specify Co	f Hispenic Origin? (Speuben, Mexican, Puerto o Specify:	ecify Yes or No- Rican, etc.)	14. Race Blee Specify	e - American Indie k, White, etc.		
5-0	72 hc	ee	15. Decedent's E (Specify only highest gr	's Education 16		Decedent's Usuel Occ (Give kind of work don life. DO NOT use reti	supetion	na	16b. Kind of Busine		ess/Industry	
121	ithin nan ".	Completed	Elementery/Secondery (0-12)	4 College (1-4or	5+)	life. DO NOT use reti		9	DDTIAMA			
7	filed with Hygiena. fther than		47 Fathada Nama /Finst Middle Lass			INSURANCE		(F <sup>100</sup> . 1 A A <sup>2</sup> 1.41	PRIVATE			
and	be died be dot	Be								Θ)		
7	2 should be one one of the should be less than the short of the short	2	WILLIE DAVIS  19e. Informent's Neme/Relationship (	Time Printi	10	o. Meiling Address (Stre	ROSA M		City or Town	State Tie Codel		
Ma			ALTHEA BUNN		CTERI					Stete, Zip Code)		
Baltimore,	of He of He w		20e. Method of Disposition 1Å Buriel 2 □ Cremation 3 □		20b. Place of cemete	514 PERRY S of Disposition (Name of orly, cremetory or other p AND NAT. CE	lece)	Dete		City or Town, Ste	ite	
Ħ	permit. Pag Department Important: It any Injury o		4 ☐ Donetion 5 ☐ Other (Special Signature of Funeral Service Lice		TAKIL	CEM. JULY 3, 1997 LAUREL, MD.  Address of Fecility JOHNSON & JENKINS INC.						
Ba	permit. Pag Department Important: I any injury o		Belia John 716 KENNEDY ST. N.W. W.D.C. 20011									
			<ol> <li>Pert1. Enter the disease, or confishook, or heert failure. List only</li> </ol>	plicetions that cause one cause on each	ed the deeth. Do line.	not enter the mode of d	ying, such es cardiac c	r respiretory er	rest,	Approx	ximete el Between	
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Ž	S 00 TO	2	1 Yes 2 No	Hospitel: 1 Inpat	ient 2 ER/O	utpetient 3 DOA	Other: 4 Nursing Hor	me 5 Resid	lence 6 DOth	er (Specify)		
Division o	ng Pl fter th	ü	27. Menner of Deeth 1 ☑ Neturel 5 ☑ Pending	28e. Dete of In (Month, D	ury 28b.	Time of 28c. In Injury	jury et :	28d. Describe h	be how injury occurred			
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ā	is effe	Cert	4 Homicide	building, e	fc. (Specify)			City or Tou	n, Stete)			
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	To the To the Comp	X	29b. Signeture end title of certifier				nse number		29d. Date signed	d (Month, Dey, Ye	er)	
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(	9			der mo	death (Item 23e)	North Can	4/ ST NE	Cush	laston .	Oc		
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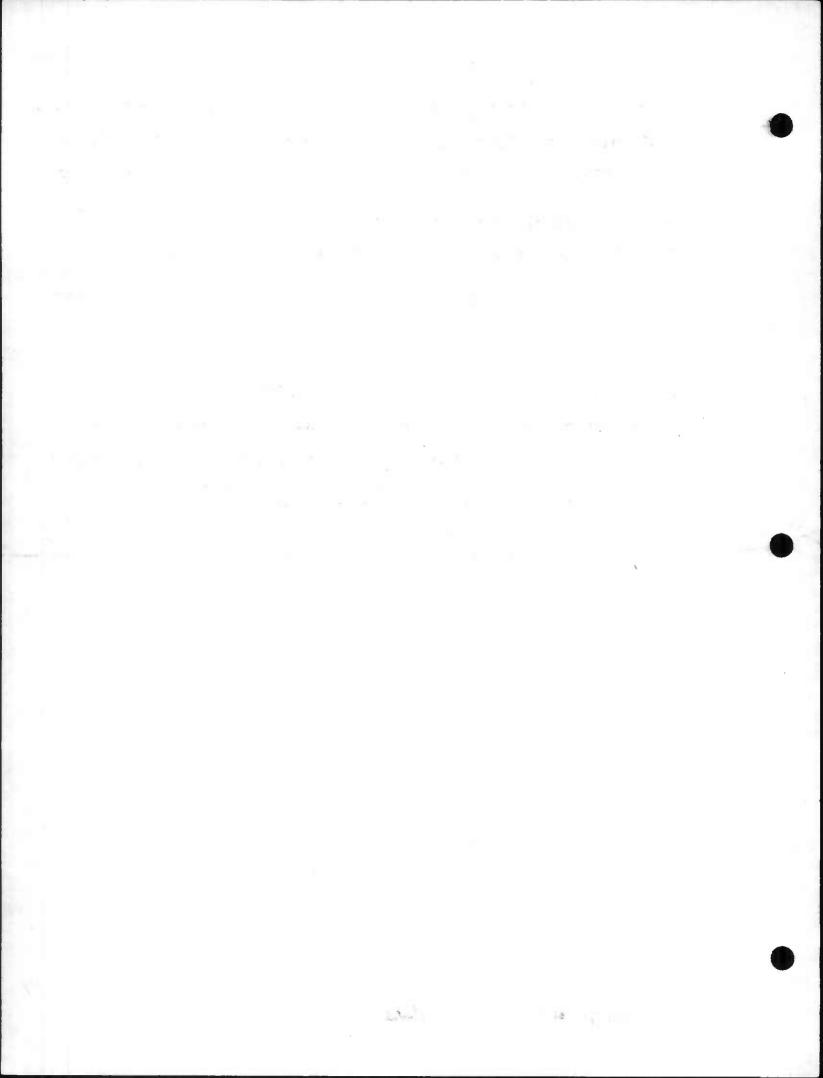
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Dey **Physician** JAMES EDWARD 30,1997 DANSBY 1:25 PM JUNE /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 2621 OXON RUN DRIVE TEMPLE HILL PRINCE GEORGES If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 4-29-52 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Months 10 M 20 F 45 Yrs. 578 70 0558 Director WASH.D.C. Usual Residence of Decedent with the Merylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or itema 23a or 28a-f show stical Examiner must be notified at X□ Yes 2□ No Director MD PRINCE GEORGES TEMPLE HILL 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2621 OXON RUN DRIVE 20748 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Reca - American Indian. Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Heelth and Mental Hygiena. Important: If item 27 is marked other than "natural", or iter any injury or other treumatic event, the Medical Examine any injury or other treumatic event, the Medical Examine Spice. 1 Never Married 20 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No BLACK Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) unavail HOSPITAL 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be CLEVE P DANSBY MARTHA Unknown 19e. tnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ELAINE DANSBY (WIFE) 2621 OXON RUN DRIVE TEMPLE HILLS, MD 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑Burial 2 ☐Cremetion 3 ☐Removel from State
4 ☐ Ophetion 5 ☐Other (Specify) HARMONY MEMORIAL PARKUULY 3,1997 LANDOVER, MD 22. Name end Address of Fecility RALPH WILLIAMS FUNERAL SVC 517 11th STREET S.E. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart feilure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical colon concer 15 mm the Examiner Due to (or es e consequence of) requires that the death certificate be axecuted physician and the buriel-transit Exami Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of): 80 esn for ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ 24b. Were eutopsy findings eveilable prior to completion of ceuse of death? Completed 24a. Wes en eutopsy performed? certificate has b lirector, page 2 s NO 1□ Yes ★ No 1 ☐ Yes 2 ☐ No Attanding Physician: director, 25. Wes cese referred to medicel examiner? Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of tnjury (Month, Dey Year) funeral 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending death. investigetion 1 Yes 2 No 2 Accident ofter death Director: 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 6 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end menner steted. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) July anne D35206 wy 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Livingston Rd. Suite 101 Ft. Washington Md. 2044 MD 11701 William Tanner

32 Registrar's Signature

State Registrar 31. Date filed (Month, Dey, Year)

JUL 11 1997



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 19b per FH G-750 8/5/97 dh 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Lillian I. Emmitt 0605 AM June 28 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, 9. Birthpiece (State or Foreign (Month, Dey, Year) November 8, 1□ M 200 F Months Days Hours Min Country 0h10 89 Yrs. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland | Montgomery Kensington 10f. Zip Code 10g. Citizen of Whet Country? 2905 McComas Avenue 20895 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XNo Specify: Specify: Year or Detes: White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) housewife own home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Bartkowski Rosalia Koperski 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2<del>0905</del> McComas Avenue, Kensington, Maryland 20895 Robert J. Emmitt 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 6-30-97 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 22. Name and Address of Fecility
Rapp Funeral Services, P.A.
933 Gist Avenue, Silver Spring, Maryland 21. Signature of Funeral Service Licensee. 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. 20910 Approximate Intervel Between Onset end Deeth Edema himonary min Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of) Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably A BUnknown 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth?

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

r than "natural", or items 23a or 28a-f show the Maxical Examiner must be notified at

permit. Pages 1 end 2 should be filed within 72 hours efter a Department of Health and Mental Hygiene. Important: if Nem 27 is marked other than "natural, or itel mortant: if Nem 27 is marked other than "natural, or itel and yilury or other traumatic event, the Mexical Examination."

Baltimore, Maryland 21215-0020

Box 68760.

P.O. I

Records,

Division of Vital

Funeral

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Completed

Be

with the Marylend

deeth v

5. Social Security Number

271-09-4303

10e. Street end Number

11 Maritel Status

Usual Residence of Decedent

3 ☐ Widowed 4 ☐ Divorced

Elementery/Secondary (0-12)

12

20e. Method of Disposition

Immediate Ceuse (Final

Illen

10b. County

disease or condition resulting in death) The law requires that the death certificete be executed

Physician/Medical Examiner physician and s the buriel-transit 98 signed t þ Completed page 2 Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice stelly filled in by the funeral director, to Be 2 Certification:

certificate

24 hours

5

within 24 hour To the Funer completely file To the

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in deeth) Lest

1 Yes 2 No. 2 No 1 Yes 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 SER/Outpetient 3□ DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending investigation 1 Tyes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide

29a, Certifier

1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated.

29b. Signature end title of certifier

29c. License number

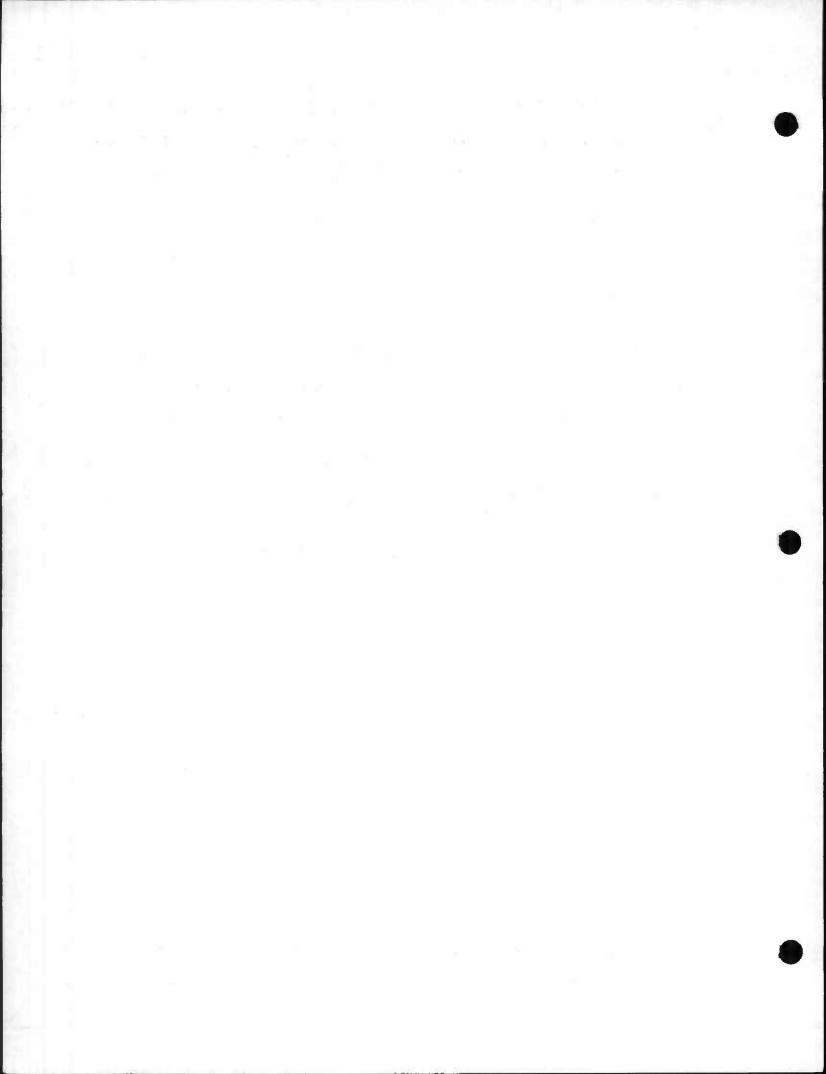
29d. Date signed (Month, Dey, Yeer)

30. Neme end eddress of person who completed dause of death (Item 23e) (Type, Print)

Center dove, Rockville Mb 20850 MIGREIU 1000 MARTIN 1997 32. Registrare Signature Rands 31. Date filed (Month.

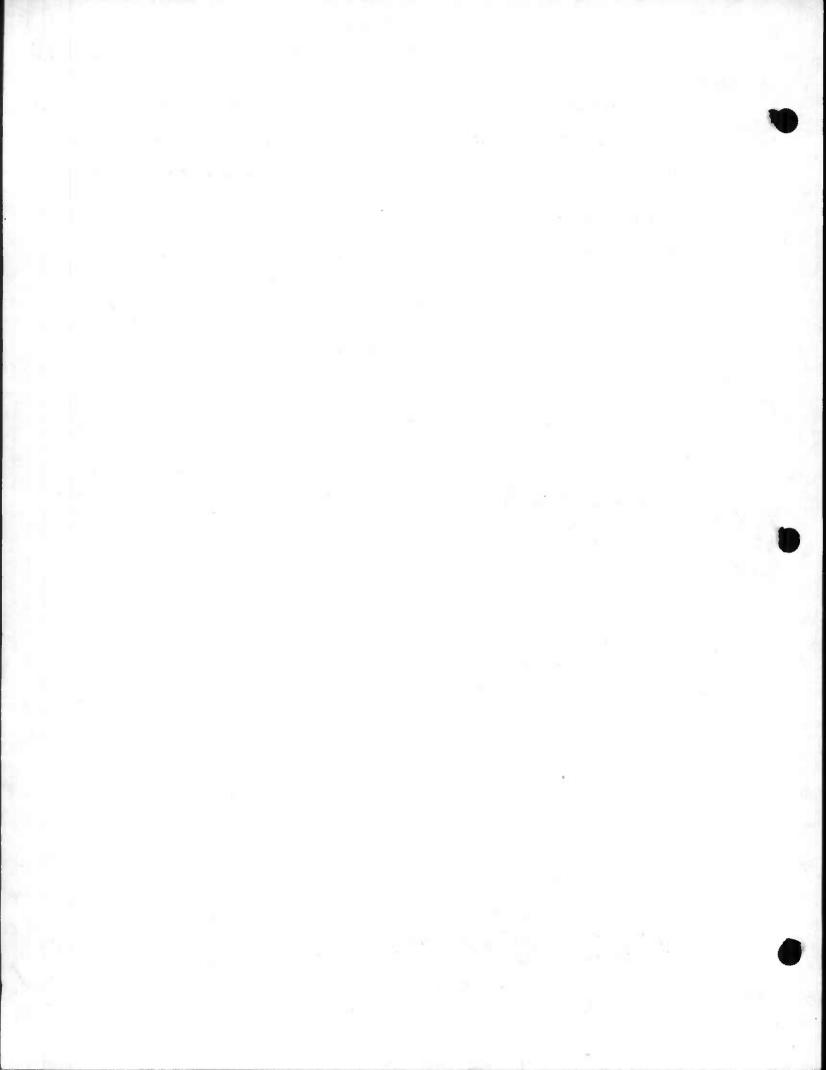
State Registrar

Medicai



State of Maryland / Department of Health and Mental Hygiene 97

						Ce	rtificate o	f Death			Reg. No.			
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			Usuai Residence of Decedent		12					pury 9,	1724	IIId.	Lalla	
	dand		10a. State 10b. County		10c. C	City, Town or Lo	ocation						10d. Inside C	ity Limits
	Man,	ō	Maryland Montg	omerv		Cab	in John						1 🗆 Yes	2 🗆 No
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_	ter d	F	1 Never Married 2 Marri	Armed F	orces? 2 🕅 No	0,0.	Was Decedent of If Yes, specify Cu	ban, Mexice	n, Puerto	Rican, etc.)	В	lack, White,		
20	rs at	by	3X Widowed 4 □ Divorced	if Yes, G Yeer or I	ive		1□ Yes 2∏ N	Specify:			Spec	oify:	L	
ŏ	within 72 hours after deeth with the Maryland ena. than "netural", or items 23a or 28a-f show he Medical Examinar must be notified at		15. Decedent		50103.	16e Dece	dent's Usuai Occ	upetion			16b. Kind of		hite	
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Maryland 21215-0020	should be and Mentei I marked of umatic eve	Be C	George J.							e Robin		00)		
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ds,	8 6 8	d by								Ode Wee		24b W	ere autopsy f	findings
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€ Sec	2 5 0	ig.											death?	
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II	Physician: The this cartificate ral director, page	Be	25. Wes case referred to medical exeminer?					26. Plece	of Deet	h (Check only o	one)			
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0	ding Ph h. After th funeral		27. Manner of Death 1 X Naturel 5 ☐ Pending	28e. Date	of Injury th, Day Year)	28b. Time of Injury	28c. Inj	ury et ork?		28d. Describe	how Injury occ	urred		
Division	Attending or death.	ati	2 ☐ Accident investig	ation				∃Yes 2□	No					
5	or Attendation after deati	tlfic	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Piece	e of Injury - At I		eet, factory, office	•		28f. Location (a City or Tox		n <i>ber</i> o <i>r R</i> ur	el Route Num	ber,
ā	s after s after si Direct	Certification:		20110	ing, oto. (opeo	·· <b>y</b> /				0.19 0.7 10	,,, 0,0,0,			
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier Certifying	Physician: To the	best of my kn	owledge, death	occurred et the	time, date en	d place,	end due to the	cause(s) end	menner es s	steted.	
	n 24 n 24 He Fi	edicai	(Check only 2 Medical E	xaminer: On the b end men	esis of examin ner steted.	ation end/or inv	estigation, in my	opinion, dee	th occurr	red et the time,	date and pleci	e, end due t	o the ceuse(s	5)
	To the To the Some	Σ	29b. Signeture end title of certifier	- 1		11	29c. Licer	nse number			29d. Date sign	ned (Month,	Dey, Year)	
	2		V; -11 -	7/1	1	11/100	1	124	00		1	75	7 100	7
•			30. Neme end eddress of person v	the completed on	se of death (Ita	m Zial (Tune	Print)	27	-(0	l C+	nune	2 1	1 177	
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	Sta	to	31. Dete filed (Month, Day, Year)	gooden 32. F	Registr <b>R</b> r's Sign	nature -	1160	iandu	3000	a ( /	011	Jey	- lary	1ang
	Registr		JUL 0	1 1997	Julia	Davidson	andelle					2_	082	~



10f. Zip Code

1 ☐ Yas 2X No

20879

Gaithersburg

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Month JULY 1, 1997 1:40 PM **EDLUND** 4a. Fecility Nama (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death 19310 CLUB HOUSE ROAD, APT. #218 GAITHERSBURG MONTGOMERY If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Dey, Year) 7. Aga (In yrs. last birthday) 6. Sax Birthplaca (Stata or Foraign Country) 1 M 2 F Months Yrs. 79 1918 31, New Jersey 10c. City. Town or Location 10d. Insida City Limits

Was Dacedant of Hispenic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puarto Rican, etc.)

Specify:

1 ☐ Yas 2 ☐ No

10g. Citizan of What Country?

United States

16b. Kind of Business/Industry

Specify

July 2, 1997

14. Raca - Amarican Indian, Bleck, Whita, atc.

White

**Funeral** Director

**Physician** 

/Medical

Examiner

5. Social Security Number

140-05-0002

Maryland

10e. Street end Number

10a. Stata

Director

2

Usual Rasidence of Dacadant

1 ☐ Navar Married 2 ☐ Married

3 Widowad 4 □ Divorcad

10b. County

Montgomery

15. Dacadant's Education (Specify only highast grada completed)

30. Nama and eddrass of parson who completed causa of deeth (Itam 23a) (Type, Print)

32. Registrar's Signature

12. Was Decedant Evar in U,S. Armed Forcas?

1 ☐ Yes 2 ☑ No If Yas, Giva Year or Datas:

19310 Club House Road, #218

death with the Marylend show I is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer.
Department of Health and Mental Hyglene.
Important if fleen 27 is marked other than "natural", or flee any injury or other traumatin avera-

Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

sician end bunal-transit requires that the death certificete be executed ettending physician for use es the buna signed by the el been hes page 2 The certificate Hospital or Attending Physician: After this death. efter death in by t 24 hours

Records, P.O. Box 68760.

Division of Vital

Examiner iclan/Medical Physi by Completed Be 2 Certification: Medical To the F within 2

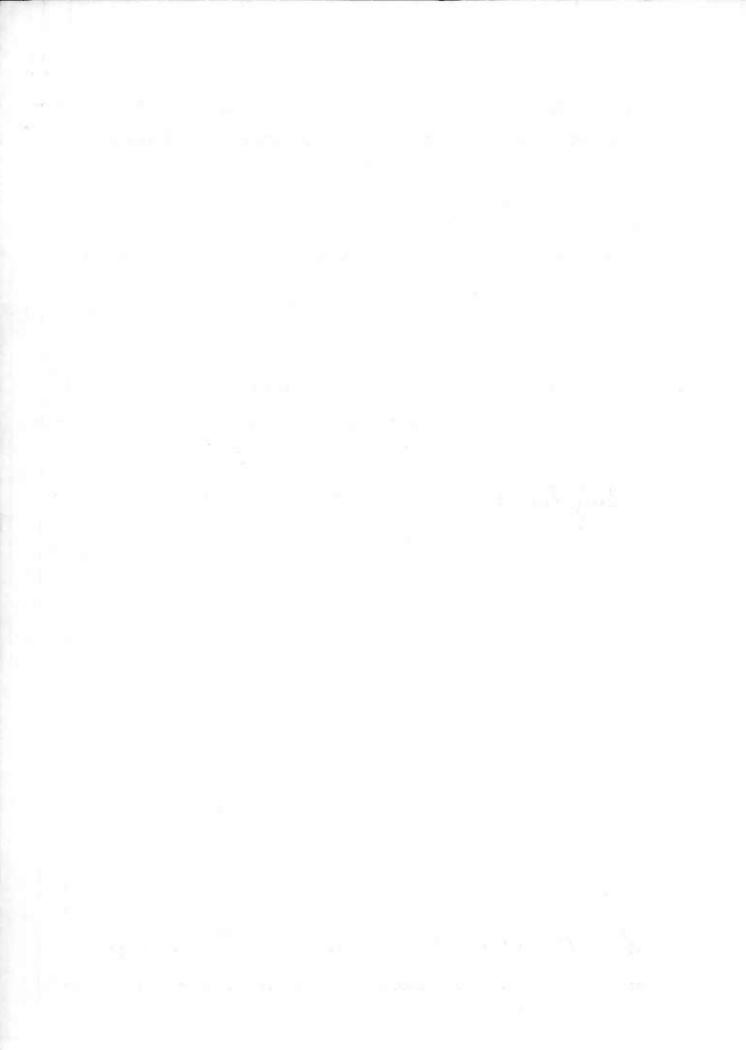
16a. Dacadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elamantary/Secondery (0-12) College (1-4or 5+) Teacher Elementary Education 17, Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be Patrick 2 Dunn Frances Sullivan 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Coda) Barbara Beall, Daughter 798 Kimberly Court, East, Gaithersburg, MD 20878 20b. Placa of Disposition (Name of comatery, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Ramovel from Stata July. 4 Donation 5 Othar (Specify) Gate of Heaven Cemetery 1997 Silver Spring. 22. Nama and Addrass of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD 20877 or complications that causad tha death. Do not antar the mode of dying, such as cardiac or respiratory arrest, st only one ceuse on each line. Approximata Onsat and Deeth Immediata Causa (Final disaasa or condition rasulting in daath) Dua to (or es a consequance of) Sequantially list conditions, if any, leading to Immediate causa. Enter Underlying Causa (Disaasa or injury thet Initieted avants resulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequanca of): Pert II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Wara autopsy findings eveilabla prior to completion of cause of death? 24e. Was an autopsy performed? 1 🗆 Yas 2 No 1 Tyas 2 No 25. Wes casa refarred to medical axaminar? 26. Place of Daath (Check only ona) 1 Yas 2 No Othar: 4 ☐ Nursing Homa 5 🖾 Rasidance 6 ☐ Othar (Spacify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending invastigation 1 XNatural 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida 6 Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rurel Route Numbar, City or Town, Stete) 4 Homicida 1 Cartifying Phyalclan: To the best of my knowledga, deeth occurred et tha time, dete end place, and dua to the causa(s) and mannar as steted.

2 Medical Examinar: On the besis of axamination end/or invastigation, in my opinion, daath occurred at tha tima, data and pieca, and dua to tha ceuse(s) and mannar stated. 29a. Certifie (Check only one) 29b. Signature and the of cartifian 29c. Licensa number 29d. Date signad (Month, Day, Yaar)

D15046

Stephen J. Newman, M.D., 19261 Montgomery Village Avenue, Gaithersburg, MD 20879

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year July 3, 1997 2:00 AM Ronnie Ealy /Medical 4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Prince Georges Lanham 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) **Funeral** 1**№** M 2□ F Days Hours Min. Yrs 254-88-1303 44 Director Georgia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryta ? Is marked other than "natural", or Items 23a or 28a-f shor traumstic event, the Medical Examiner must be notified at Maryland Prince George's College Park 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4714 Lakeland Road 20740 USA Funeral 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Tes 2 No Specify: Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 3+ Accounting Technician Private permit. Pages 1 and 2 should be filled Department of Health and Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event.) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 2 Frank Ealy Dorothy Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Denise Roland/Sister 3971 High Chaparral Drive, Martinez, Georgia 30907 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olive Memorial Gard. 7/7/97 Augusta, Georgia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home Nana A. Percen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. **Physician** Acres Fernment heps /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of) physician s the burial Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 98 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. been signed by the a should be detached 23b. Dfd tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 Ø Unknown by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 TYes 2 No investigation 2 Accident Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) and manner es steted. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner steted. 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Yeer) of death (Hem 23a) (Type, Print) 150 Fortmonde Road Laurel MD 20724.

State Registrar

State of Maryland / Department of Health and Mental Hygiene 21473 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Month EDYTHE FELLS JUNE 1997 29, 330 AM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HEBREW HOME ROCKVILLE MONTGOMERY If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

MARCH 4, 1917 If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Deys 1 ☐ M 2 耳 F Yrs. Director 121-03-7596 80 NEW YORK Usuel Residence of Decadent 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6121 MONTROSE RD. 20850 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ⑤ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: by Specify: 3 ☐ Widowed 4 ₺ Divorced WHITE Completed 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 AT HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SAMUEL MULHOFFER EDNA YOUNG 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) CAROLYN S. TAIT/DAUGHTER PERNELL CT., BOWIE, MD. 20716 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremation 3 ☐ Removel from State 4 ☐ Donelion 5 ☐ Other (Specify) CHAMBERS CREMATORY 7/1/97 RIVERDALE, MD. 21. Signature of Funerel Service Liperised 22. Neme end Address of Facility \_M00091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Altzheiner's demention /Medical Immediate Cause (Final disease or condition resulting in death) Examine Due to (or es e consequence of): Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Physician/Medical Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes, 2 ☐ No Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: 1 | Inpalient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Netural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide edicai 🗺 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) end menner es steted. 29a. Certifier (Check only one) 2 Medical Examiner: On the bests of examinetion end/or Investigation, In my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end menner stated.

6105 montrose Ras, Lockville My 20852

29b. Signature end title of certifier

Russ I Feldman

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

1997 Registrar's signature

State Registrar

the Maryland

Baltimore, Maryland 21215-0020

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items 23a

"natural", or

Hygiene.

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Department of Health e Important: if Item 27 is any injury or other tra

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Hospital or Attending Physician: 24 hours efter deeth. Funeral Director: After this certifice stely filled in by the funeral director, I

24 hours

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that the death certificate be executed

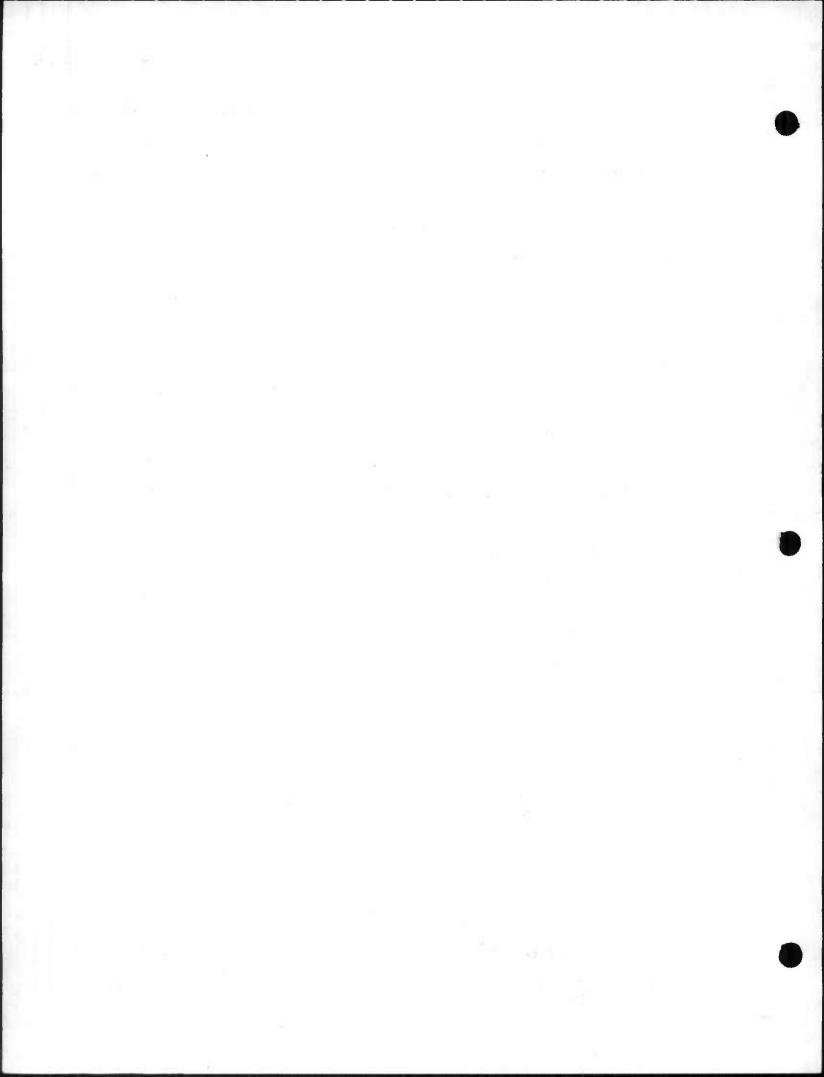
P.O. Box 68760,

Division of Vital Records.

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State of Maryland / Department of Health and Mental Hygiene 97 2 1 4 7 4

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			10		A 40 - 32 Reni	strar's Signature	704	UNUVE	100			- ,					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Day 1997 Margaret Marie Flint June 26, 12:50pm /Medical 4a. Facility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Rockville Montgomery National Lutheran Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Country)
Baltimore 1□M 20 F Months Yrs. 136-01-8919 May 19, Usual Residence of Decedant 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Md. Montgomery Rockville X Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizan of Whet Country? 20850 US 9701 Veirs Drive Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: þ 3 Widowad 4 □ Divorced Specify: White Year or Dates Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Dacadant's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Secretary Insurance 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Ernestine Besanz Byrd W. McDonald 2 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) 9701 Veirs Drive Rockville Md. 20850 Thomas White 20a. Method of Disposition 20b. Place of Disposition (Nema of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramovel from State 6/30/97 Mt. Comfort Crematory Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Compa 22. Name end Address of Fecility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, Md. 20852 23e. Pert1. Enter the disaese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer failure. List only one ceuse on each line. Approximete Intervel Batween Onset end Deeth Immediete Ceuse (Final diseese or condition resulting in daath) Examiner Sequentielly list conditions, if eny, laading to immadiate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest Physician/Medical Due to (or es e consequence of): Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown þ Be Completed 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes casa referred to medical examiner? 26. Placa of Deeth (Check only one) Other: 2 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: 27. Menner of Deeth 28c. Injury et Work? 28b. Tima of 28d. Dascribe how injury occurred 5 Pending investigetion T∐Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homicida Tertifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end mennar as steted.

| Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29a. Cartifier Medical (Check only one) 29b. Signature and title of portiller 29c. License number 29d. Date signed (Month, Dey, Yeer)

or Attending Physician: The law requiras that the deeth certificata be axecuted Division of Vital Records, P.O. Box 68760, certificate has b irector, page 2 sl funeral director, this Aftert within 24 hours efter deeth.

To the Funeral Director: All completely filled in by tha fu Hospital To the

**Funeral** 

Director

or Items 23a or 28a-f show

other traumatic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after to Depertment of Haalth end Mental Hygiena. Important: if Item 27 is merked other than "natural", or test any Injury or other traumatic event, the Medical Examinationa.

**Physician** /Medical

Examiner

burial-transit

ettending physiclan for use es the buria

signed by the e

been sig

கே. Baltimore, Maryland 21215-0020

death with the Maryland

State Registrar

31. Dete filed (Month, Dey, Year) JUL 03

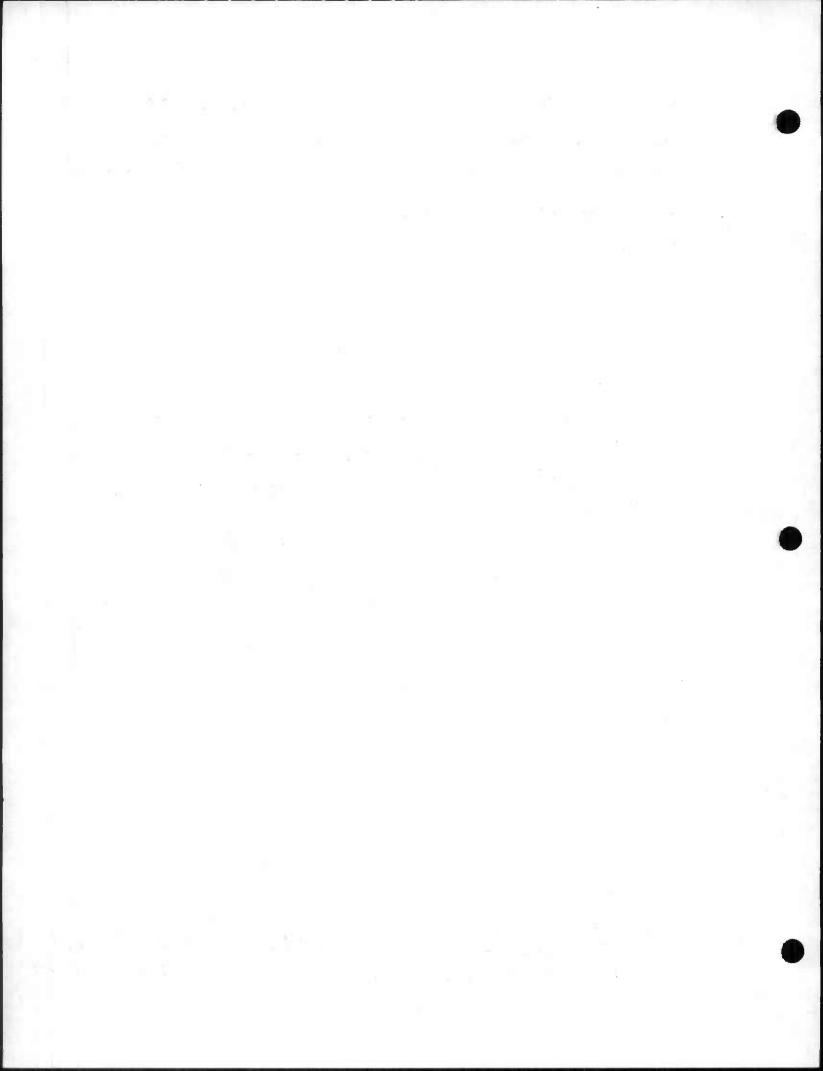
aniel

30. Name end eddress of person who

12850 5011er 32. Registrar's Signeture

cause of death (Item 23e) (Type, Print)

Middlebrook Rd. Germantour, no

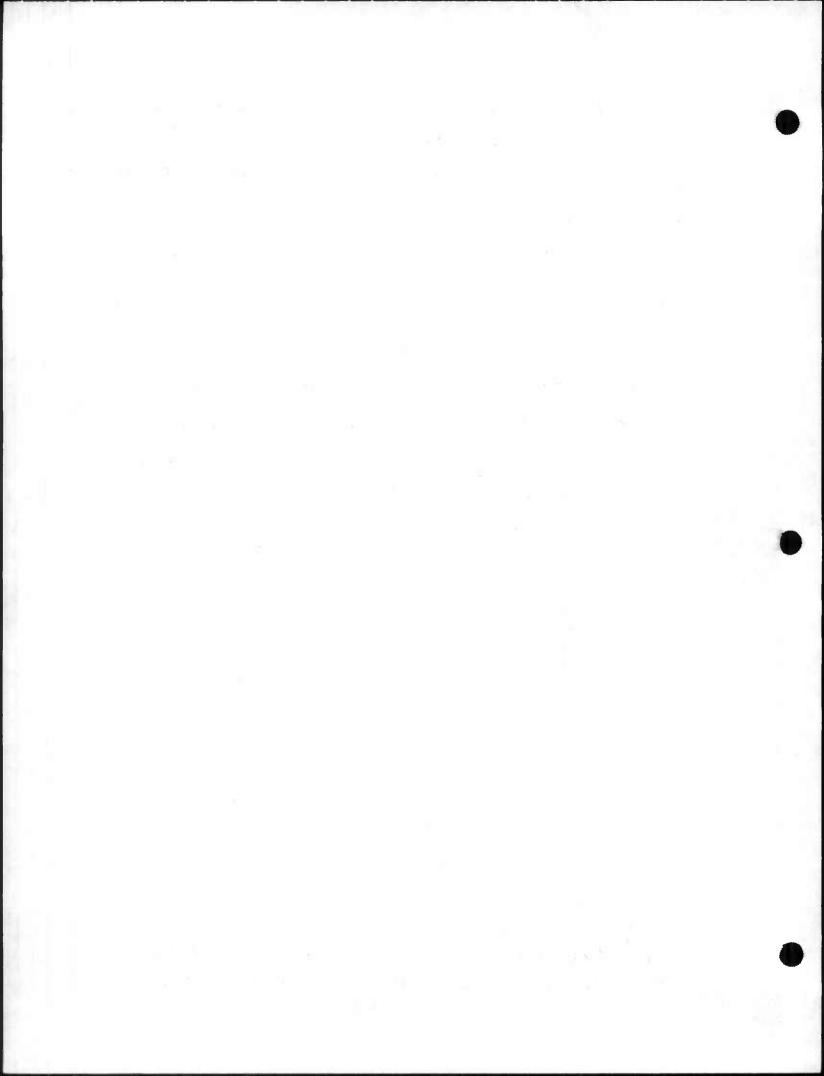


State of Maryland / Department of Health and Mental Hygiene 97

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						Cer	tificate of	Death		Reg. No.	, ,	41410
П	Physic	ion	1. Decedent's Neme (First, Middle, Les						2. Date of De	eth	Voor	3. Time of Deeth
J	/Medi			oster					June 3	29, <sup>Da</sup> 1997	7 Yeer	3:30 PM
и	Exami	ner	4e. Fecility Neme (If not institution, give					4b. City, Town, or L	ocation of Deet			
			Manor Care Healt			-	lf Linday 1 Van	Potomac	T		gomery	
	Funeral Director		5. Sociel Security Number 6. Se 218-09-0523	"м Жог ″	Age (In yrs. 9	last birthdey) Yrs.	If Under 1 Yea Months Deys		8. Date of Bio (Mooth, Da April 3	0, 1907	9. Birthp	placa (Stete or Foreign ntrx) y 1 and
	land land		10a. State 10b. County		10c. City	, Town or Lo	cation				1	Od. Inside City Limits
	Mary Fed	ğ	Maryland Montgome	erv	Beth	nesda						1 ☐ Yes 2 No
	r 28s	rec	10e. Street end Number				10f. Zip Code			10g. Citizen of	Whet Coun	ntry?
	th wit	a D	4521 East West Hi	ghway			20814			United	State	es
21215-0020	permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Heelth end Mental Hygiene. Important: if item 27 is marked other than "natural," or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinat must be notified at ances.	by Funeral Director	11. Maritel Status  1 Never Merried 2 Married  3 Widowed 4 Divorcad	12. Was Decede Armed Force 1  Yes 2 If Yes, Give Yeer or Dete	No.		Vas Decedent of Yes, specify Cul ☐ Yes 2 X No	HispenIc Origin? (Spoen, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	- 14. Re- Ble Specii	ca - Americ ck, White,	
5-0	72 ho	ted	15. Decedent's Edu (Specify only highest grad	ication		16e. Deced	ent's Usual Occu	petion	cina	16b. Kind of B	usiness/Ind	dustry
121	rithin ne.	Completed	Elementery/Secondary (0-12)	College (1-4)	or 5+)			during most of work ad)	ung			
2	led w tygier her th		17. Father's Neme (First, Middle, Last)			haird	lresser	T		own bu		5 S
Maryland	wild be fi Mental F arked of	To Be	William Henry Cro	SS				Lena Rel			me)	
Mar	2 sho end is m		19a. Informent's Neme/Relationship (T)			ļ		t end Number or Rui				
	l end leelth im 27 ther t		John Gordon Foste	r, Jr.	not n			Road, Beth				81/
10	or of		20e. Method of Disposition  1)(☐XBurial 2 ☐ Cremetion 3 ☐ F		I(A)		sition (Neme of atory or other ple		Date	20c. Location		
Baltimore,	permit. Peges 1 end : Depertment of Heelth Important: if item 27 i any injury or other tr.		4 Donetion 5 Other (Specify)		Pa		Cemeter	y ,7	-2-97	Baltimo	re, M	laryland
Ba	Depermination of the property		21. Signeture of Euneral Service Licanu	" <i>[]</i>	0	Ra	pp Fune	ess of Facility ral Servio	ces, P.	Α.		
	Physician /Medical		23a. Pert1. Enter the disease, or complishock, or heart failure. List only of Immediete Cause (Final disease or condition				r the mode of dy	Avenue, Sing, such es cardiac		0.		Approximate Interval Between Onset and Deeth
н	Examiner		resulting in deeth)	a. Aspii		es e consequ					1	10 days
4	p #	iner		Cerel			Accident					3 months
	death certificate be executed to estending physicien and of for use es the buriel-trensit	Examiner	Sequentially list conditions,	0. ————	Due to (or	es e consequ	rence of):					
68760,	be ex clen		Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	o								
387	physl s the	Medical	thet initieted events resulting in deeth) Lest		Due to (or	es e consequ	ence of):					
×	certifi ding ise es			d								· .
Box	leath certifice ettending pl if for use es t	Physician	Death Other desidence						1 33 34			
0	by the detected	hys	Pert II. Other significant conditions cor	itributing to deatr	DUT NOT FOSU	iting in the un	derlying cause gi	ven in Pert I.		tobacco uee co Yes 2□ No		the cause of death? pably 4 ☐ Unknown
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R	The lev ate hes page 2	E O							10	Yes 2 No		Yes 21 No
ita		BeC	25. Wes case referred to medical					26. Place of Deet				2100 213110
f <	Physician: this certific rel director,	TOE	exeminer? 1  Yes 2 No	lospital:	itient 2 🗆 i	ER/Outpetient	3□ DOA Ot			dence 6 □Oth	ner (Specify	()
ion of	IIng After fune		27. Manner of Deeth 1 Meturel 5 ☐ Pending 2 ☐ Accident Investigation	28e. Dete of Ir (Month, I	njury De <i>y Year)</i>	28b. Time of Injury	28c. Inju Wo M 1			how injury occur		
Division	of or Attend efter death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Pleca of building,	Injury - At hore	me, farm, stre	et, factory, offica		28f. Location ( City or To		ber or Rura	Route Number,
	To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by	edical C	29a. Cartifier 1 Certifying Phys	pician: To the best ner: On the basis end menner	of examinati	riedge, death on end/or inve	occurred et the ti estigetion, in my	me, date end pleca, opinion, deeth occur	end due to the red et the time,	ceuse(s) end m date end plece,	enner es st end due to	eted. the ceuse(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1.			29c. Licen	se number		29d. Date signe	d (Month, L	Dey, Year)
	6		30. Nemejand eddress of person who co	Oll modern	O death (lear	23a) (Tuna 1		1319		June 30	, 199	7
			Loreto S. Albiol,					, Chevy	Chase.	MD 208	15	

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death Month **Physician** Arthur Byrd Freeman June 24,1997 6;10pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Min. Spring Month, Day, Year) Holy Cross Hospital Montgomery 5. Social Security Number 6 Sex If Undar 1 Yaar 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1X M 2□ F Months Yrs Director 72 May 29, 1925 410-20-9328 Tennessee Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a 4524 Bennion Road 20906 U.S.A. death Funeral items : 11. Marital Status 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give Yaar or Dates: Baltimore, Maryland 21215-0020 ö 1 ☐ Yes 2 ₩ No Specify. Specify þ 3 ☐ Widowed 4 ☐ Divorced "natural", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 Construction-Self Employed Construction marked other Alth and Mental Hvv 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: if item 27 is marked cany injury or other traumetic ev. Carl Franklin Freeman Mary Magdeline Tipton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N. Jeanne Freeman 4524 Bennion Road Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 6/30/97 Silver Spring, Maryland 21. Signatura of Funeral Sen 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest,

Approximata Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final . LUNG CANCER WITH METASTASIS BONE disease or condition resulting in death) TWO YEARS Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-tran Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): Ses attending for use as P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? detached signed by t 1 Yes 2 No 3 Probably 4 ☐ Unknown Records, à been sig Completed 24a. Was an autopsy performad? 24b. Were autopsy findings available prior to completion of ceuse of deeth? page 2 1 ☐ Yes 2 No this certificate 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) examiner? Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral i 28a. Date of injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) JUNE 25, 1997 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SILYER SPRING S ANDULLAH KHAN MA 8830 CAMERON ST #502 MD 20910 100732. Registars Signature 31. Date filad (Month, Day Year) State Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Month Dey 1997 Ronald. F. 28, Frush June 11:15P. /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 3019 Chapel View Drive Beltsville Prince George's if Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day. 9. Birthplece (State or Foreign **Funeral** Months Days Hours XX M 2 F August 52 Yrs. 5,1944 Maryland 217-42-2206 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
1 ☐ Yes 2 ☐ No 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinet must be notified at Maryland Prince George's **Beltsville** Director the 10f. Zip Code 20705 10e. Street end Number 10g. Citizen of What Country?
United States Pages 1 and 2 should be filed within 72 hours after death with I ent of Health end Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or : 3019 Chapel View Drive Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married XXMarried 21215-0020 White 1 ☐ Yes 2 XXIo Specify: Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Business Owner Private Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ara Virginia Reed Clarence F. Frush 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Barbara Frush (wife) same as #10 other i 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State i of h 1 ☐ Burial 2XX remation 3 ☐ Removal from Stete permit. Page Depertment of Important: If any injury or once. Metropolitan Crematory 6/30/1997 Alexandria, Virginia 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 tions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, 23a. Part1. Enter the disease, of complications shock, or heert failure. List only one Approximate Intervel Between Onset end Death Physician /Medical Immediate Ceuse (Finel disease or condition resulting in death) METASTATIC MELANOMA YEAR Examiner Due to (or es e consequence of) Physician/Medical Examiner The law requires that the death certificate be executed buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events resulting in deeth) Last Due to (or es e consequence of): Box 68760. physician the Due to (or es e consequence of): 98 use signed by the e P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy Completed performed? page 2 hes certificete 1 ☐ Yes 2XXNo 1 ☐ Yes 2 No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5000 Residence 6 Other (Specify) 2 1 Yes 2 No this 28e. Date of Injury (Month, Day Year) funeral 27. Manner of Deeth 28c. Injury at Work? After t Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 24 hours efter death.

Funeral Director: A 1 ☐ Yes 2 X X o 2 ☐ Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Xertifying Phyelclen: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 20 June 30, 1997 person who completed cause of deeth (Item 23e) (Type, Print) Joseph M. Haggerty, M.D. 9707 Medical Center Dr., #300 Rockville, Maryland 20850 1997<sup>32. Registral's</sup> Signature State

who Davidson-Randess

**DHMH 16 Rev 6/95** 



State of Maryland / Department of Health and Mental Hygiene

21479

						Ce	ertificat	e oi	f Death			Reg. No.			
			1. Decedant's Nama (First, Middl	a, Last)							2. Data of De	eth		3. Tima o	of Death
	Physic		Mary P.	Farrell							Month June	26,	1997	7:45	P.M.
H.	/Medi Exami		4e. Fecility Nama (If not institution	n, give street and r	number)				4b. City, To	own, or Lo	cation of Deat		ty of Deeth		2
	Exami	iei	12512 Chelton						Bow	_				eorge'	C
-	-	_	5. Social Sacurity Number	6. Sex	7 Age //g v	rs. last birthday	If Under	1 Yea			P. Data of Bir	_	-		
	Funeral Director		131-10-6330	1 M 2 X	7. Aga (iii y	rs. musi <i>birtinda</i> j Yrs.	Months	Day		Min.	8. Data of Bir (Month, Da	7,1920	Pen:	place (Stata intry) nsylva	or Foraign
			Usual Residence of Dacedant	7141							oun.	,,,,,,	1		
	and and		10a. Stata 10b. County		10c.	City, Town or I	ocation							10d. Insida C	City Limits
	Aary Bah	ě	N 1 1 D .	0										1 Yas	2 No
	288 288	Director	Maryland Princ	e George	S BC	owie	101 7%	0-4-				10- 01	(100 -1 0-		
	E 9 8	ត់					10f. Zip					10g. Citizen of			
	ath 123	Funeral	12512 Chelton				207					United			
	tem de	une	11. Marital Status	Armed I		U,S. 13	. Was Daced If Yas, spec	dant of cify Cu	Hispanic Or ban, Maxicai	igin? (Spe n, Puerto	ecify Yas or No Rican, atc.)	)- 14. Ra	ace - Amari eck, Whita,	ican Indian, , etc.	
2	filed within 72 hours after death with the Maryland Hyglene. ther then "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at		1 Navar Married 200 Marr	If Yas (	a 2 ☑ No Biva	No	1□Yas					Spec	w. Ca	ucasia	n
3	rai.	d by	3 Widowed 4 Divorced	Yaar or								Орос	.,.		
ñ	72 h natu	Completed	15. Decedan (Spacify only highas	t's Education	1)	16a. Dec	edent's Usua	al Occi	upation	at of worki	ina	16b. Kind of I	Business/Ir	ndustry	
0700-01717		npf	Elementary/Secondary (0-12)		(1-4or 5+)				a during mos red)						
V	filed with Hygiene. other than	Ö	12			Home	Makeı	r				Own He	ome		
Maryland	0 = 0 5	Be	17. Fether's Neme (First, Middle,	Last)					18. Moth	ar's Nama	(First, Middle	, Maidan Suma	.me)		
0		L P	William Stanle	y					Marg	aret	Croni	n			
9	S D E E	-	19a. Informant's Name/Ralations	hip (Typa, Print)						ar or Rura	al Routa Numb	er, City or Town	n, State, Zi	ip Coda)	
	and 2 ealth a n 27 is		Thomas J. Farre	11/Huban	.d	Same	as #	10							
pailimore,	- 1 2 5		20a. Mathod of Disposition		20b	. Place of Disp	osition (Nan	na of			Data	20c. Location	- City or T	own, Steta	
2			1X Burial 2 □ Cramation		n Stata	camatary, cri				6	/30/97	Crown	evill	o MD	
2			4 □ Donation 5 □ Other (S		LII					1	730737	CLOWII	SATTT	e, 111 <i>D</i>	
0	permit. Pag Department Important: If any Injury o		21. Signature of Funeral Service	Licensee	0.40	12	Rober	t E	ress of Facili	ns Fi	meral	Home, I	nc.		
_	40260		Samu K/	froon	1)							e Md. 2			
			23a. Part Finter the disease, or shock, or heart failure. Light	emplications that	caused the de	eath. Do not e	nter the mod	e of dy	ring, such as	cardiac o	or respiratory a	rrest,		Approxima Interval Be	ba Decement
	Physician		0											Onset and	Death
	/Medical		Immediate Cause (Final disease or condition	-	ممامده	me - il			dent					1.0	
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	icate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ı	Due to	(or as a cons	iquence of):						16	U	
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ġ	0 9 8	ysi	Part II. Other significant condition	ns contributing to	death but not r	esulting in the	underlying a	ause g	given in Part I	l.	23b. Did	tobacco use c	ontribute t	to the cause	of death?
L	that the ed by th detach										10	Yes 251M6	3 □ Pro	obably 4	Unknow
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5	v requires been sign should be	Completed									24a. Was perfo	an autopsy ormed?	an	řere autopsy vailable prior	10
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VIIBI		Be C	25. Was case referred to medical						26 Place	o of Death	(Check only	arge Reziden		X-105	11000
5		o B	examiner? 1 ☐ Yes 2 ☐ Nor	Hospital:	Inpatient 2	☐ ER/Outpatie	int 3□ DO	. 0	History.		-	dence 6 □O	One /Cons	akat .	
5		1.1	27. Manner of Defain	28a. Date	e of Injury	28b, Time						how injury occu		ny)	
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,		1000													
	Hospita 24 hours Funeral Asky filled	edical	(Check only 2 Medical I	g Physician: To the Examiner: On the	e best of my k basis of exami	nowledge, dea nation and/or i	th occurred a revestigation,	in my	time, date an opinion, dea	d place, a	and due to the ed at the time.	date and place	nanner as a	stated. to the cause	mV.
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	ا ا	Σ	29b. Signature and title of certifier	40	5/1	_	290	Licer	nse number		1	29d. Data sign	ed (Month,	, Day, Year)	
1	10	)	1 Vett	1-0	ine	3	D	D	3582	10		6/2	7/9		
1	12		30. Nama and address of person	who completed car	use of death (It	am 23a) (Type	, Print)		-				-/-		
0.0			Teer Eckberg			Gallai		Dy	Lave	土山	0 30	ME, 1	ND :	20715	_
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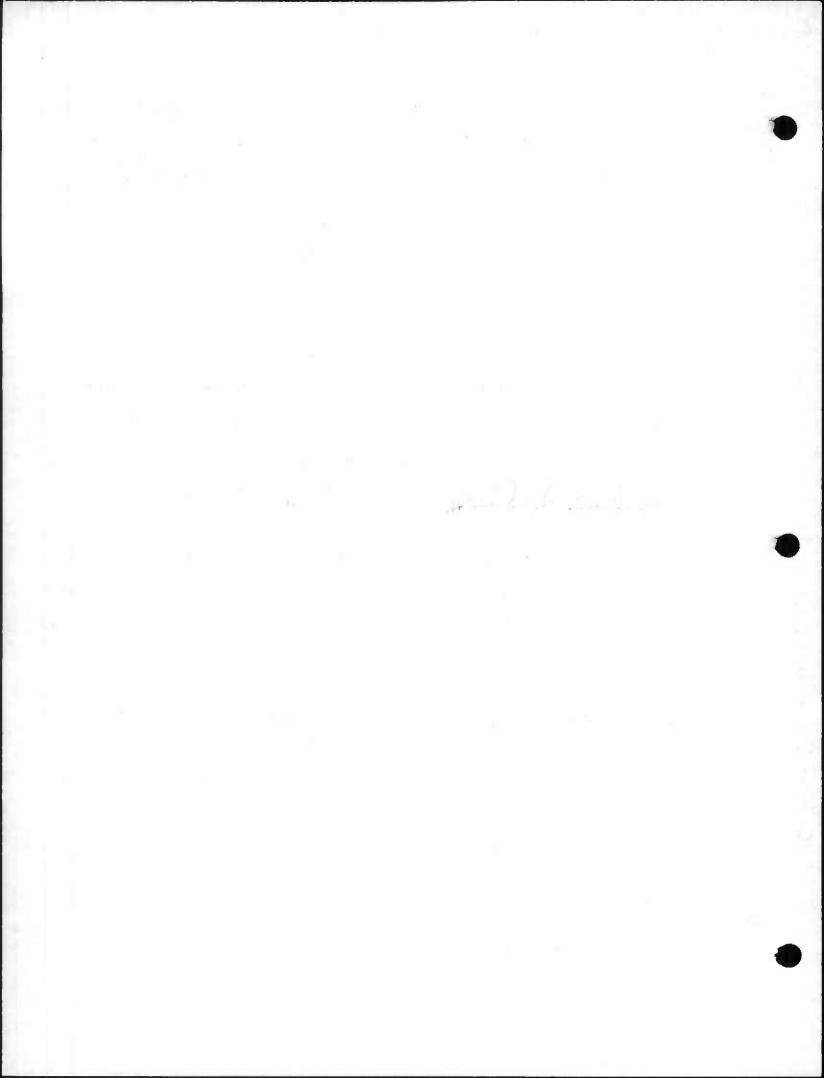
State of Maryland / Department of Health and Mental Hygiene 0.7

					, , , , , , , , , , , , , , , , , , , ,	-	tificate of	Death		leg. No.	1	21400
	Physici	an.	1. Decedent's Name (First, Mic						2. Deta of Dea Month	th Dey	Year	3. Time of Death
	/Medi		HOSIE	FAISO	N				JUNE	30	97	9:45 PM
	Examir	er	4e. Fecility Neme (If not institut	tion, give street end num	iber)			4b. City, Town, or Le	ocation of Deeth	4c. County		
			MARINER HEAL'  5. Social Security Number		7 Ann //m.um	forms brings about	if Under 1 Year	CLINTON  If Under 24 Hrs.	O Data of Dist			ORGES
	Funeral Director		UNAVAILABLE	1□M 2፟ቚF	7. Aga (In yrs.	87 Yrs.	Months Deys		8. Date of Birth Month, Day NOV • 3	69"		plece (Stete or Foreign intry) H CAROLINA
	pue *		Usual Residence of Decedent 10e. State 10b. Cour		10c. Cit	ty, Town or Loc	cation			-		10d. Inside City Limits
	Maryl f sho	lor	MD PRINC	CE GEORGES		RT WASH						1 X Yas 2 No
	with the Marylen  or 28a-f show be notified at	rec	10e. Street end Number	DE GEORGES	101		10f. Zip Code		1	log. Citizen of V	Whet Cou	ntry?
	23a o	al D	3106 MARQUIS I	DRIVE			20744		1	U.S.A.		
21215-0020	within 72 hours after death with the Marylend ene. then "natural", or items 23a or 28a-f show he Mexical Examiner must be notified at	by Funeral Director	11. Maritel Stetus  1 □ Nevar Married 2 □ M  3 ሺ Widowed 4 □ Divorce	If Yes, Give	2 🔼 No	1	Vas Decedent of Yes, specify Cub	Hispanic Orlgin? (Spoen, Maxican, Puarto Specify:	ecify Yes or No- Rican, etc.)		ck, Whita,	can Indian, , atc.
9-9	72 hours	ted	15. Deced	lent's Education		16e. Deced	ent's Usuel Occu	petlon	,	16b. Kind of Bi	usiness/îr	ndustry
2	within 7 ene. than "n	Completed	Elementary/Secondary (0-12	hast grada completed)  2) College (1-	4or 5+)			petion during most of work ed)		DD T II A TE		
12		Co	8TH	(to 1)		DOM	ESTIC WO			PRIVATE		
Maryland	S da b	Be	17. Fether's Nema (First, Middle MAJOR CHESTN)					18. Mother's Nem			10)	
7	d 2 should b th and Mente 7 is marked traumatic e	70	19a, Informent's Name/Reletic			19h Mailin	n Address /Stree	HOSIE CH			State 7	n Code)
M	d 2 at at at at at at at at at at at at at							AROLINA AV				
ē,	f Heelt f Heelt item 2 other		CLAUDE FAISO  20a. Mathod of Disposition	M-20N	20b. F	Plece of Dispos	sition (Neme of		Date	20c. Location -		
Baltimore,	permit. Pages 1 en Depertment of Heel Important: If Item 2 any Injury or other once.		1 Burial 2 ☐ Cremetio 4 ☐ Donetion 5 ☐ Other		erer		netory or other pla	EM. JUL.	9 07 M	T. OLIV	/E N	C
alti	mit.		21. Signeture of Funerel Sarvi	and the second second	W.	22.	Name end Addre	ess of Fecility			E, IN .	0.
m	Depe Impo		) no	4. Duce	~ 2	16		N FUNERAL			0010	
-			23a. Pert1. Enter the disease, shock, or heart failure. L	or complications that ca	used the deat	h. Do not ente	or the mode of dy	STREET, N.	or respiratory arr	rest,	.0010	Approximate Interval Between
	Physician		onoon or nountrainers. E	A							AAAn B	Onset end Deeth
7	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	· Hon	im Tron	1					}	dans
		<u>-</u>	resulting in death)	1/3	Due to (o	or es e conseq	uence of):					1.7
	nsit	m		b. Neu	vogeni	7	Mugh					Month 3
Ć	eath certificate be executed ettending physicien end I for use es the burial-transit	edicai Examiner	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceusa (Disease or Injury that initiated events	<u> </u>	,	or es a consequ	uence of):	+			1	110000
68760,	ysicle	Icai	Ceusa (Disease or Injury thet initieted events	c. Cere	Due to fo	ras e consequ	acticus	W'			-	years
	ntifica ng ph es th	-	resulting in daeth) Last	t .							\$	,
Box	th certendir	an		d							1	
	p 9 9	by Physician/N	Pert II. Other significant condi	itions contributing to dea	ath but not ras	ulting In tha un	derlying cause gi	iven in Part I.	23b. Did to	obacco use co	ntribute t	to the cause of death?
P.0	w requires thet the been signed by the should be detach	F.	Alzherm	1849 Des	MILLE				1 🗆 Y	res 2□ No	3 Pro	bably Winknown
ds,	signe d be d	by		1,00	· LCIVI ·						T 0.4h 14	
Vital Records,		Completed							24a. Was e perfor	med?	av cc	Vere eutopsy findings vallabla prior to completion of cause
Rec	vicien: The law certificate hes b lirector, pege 2 s	mp								4	of	deeth?
a	n: Th ficate or, pe		25. Was case referred to media					20.000.000	1 D Y		11	□ Yes No
5	Physician: this certific ral director,	To Be	examiner?	Hospital:	nationt 2	ER/Outpetient	3□ DOA Ot	her: Numing He	h <i>(Check only or</i> ome 5 □ Resid		or (Coosi	26.1
Division of	er this		27. Manner of Death	28a. Dete o		28b. Time of	28c. tnju		28d. Describe h			97
Ö	Attending in deeth.	Certification:	2 1100100111	stigetion	- Day (Gar)	Injury		Yas 2 No	_			
N	or Atte	1110	3 ☐ Sulcida 6 ☐ Coui 4 ☐ Homicide dete	mined 286. PI609 (	of Injury - At ho	ome, ferm, stre	et, factory, office		28f. Location (S City or Tow	treet end Numb	er or Run	al Route Number,
	Ital or ins efter rai Dir iled in											
	the Hospital or Attending in 24 hours efter deeth. The Funeral Director: After inpletely filled in by the fune	Medical	29e. Certifier 1 Certify (Check only one) 1 Medic	ying Physician: To the b ai Examiner: On the bas and menn	sis of examine	wledge, deeth tion end/or Inv	occurred et tha ti astigation, in my	ime, date and plece, opinion, deeth occurr	and due to the c red at the time, d	ause(s) end me lata and place,	and due t	iteted. to the cause(s)
	Tethin	W	29b. Signetura end titla of certi	fier ()			29c. Lican	sa number	2	9d. Dete signe	d (Month,	Day, Year)
1	61		Motor	Ylran	MD		D2	0362		Julu	1	1997
	3/		30. Neme and address of person	on who completed cause	of death (Item	1 23a) (Type, F	rint)	2011	# 11	AAD		-0.3
1	9		Norton E	Elson (	1525	De	lovest	KX Hy	a 115VILL	e My	20	780
	Sta Registr		31. Dete filed (Month, Dey, Yee JUL 02	1997 Jah	gistrer's Signa	Revall						

Fig. 3. \* Sugar = 30 miles

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97

_						Ce	rtificate of	Death		Reg. No	).	
	Physic	ian	Decedant's Name (First, Michael Control of the						2. Data Mon	of Deeth	v Year	3. Time of Death
	/Medi			izabeth V		ver			Ju	20	1997	0392
į.	Exami	ner	4e. Fecility Neme (If not institut						wn, or Location of		. County of Deel	
				Memorial H		na hinthatau	If Under 1 Yea		de Gra			ford
1	Funeral Director		5. Social Security Number 212-70-5540	6. Sex 1 □ M 2 🙀 F	7. Age (In yrs. le	Yrs.	Months Dey		Min. (Mon	of Birth th, Dey, Year) -24-191	9. Birt	thplece (State or Foreign buntry) MD
	pu *		Usual Rasidence of Decedant  10a. State  10b. Coun	hu	100 City	Town or Lo	antion					4011 11 01 11
	Maryla Ind at	tor		, larford	Toc. Oity,	, TOWITOI EC	Havre o	de Gra	ce			10d. Inside City Limits 1   Yas 2 No
	with the 3e or 28	<b>Funeral Director</b>	10e. Street end Number	Superior	Street		10f. Zip Code	21078		10g. Cit	izan of Whet Co	
	Jeath Te 2	era	11. Maritel Status	12. Was De	cedent Ever in U.S	i. 13. <sup>1</sup>	Was Decedent of		pin? (Specify Yes	or No-	14. Rece - Ame	
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23e or 28e-f show striportant: if item 27 is marked other than "naturel", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 9008.	by	1 ☐ Navar Married 2 ☐ Mi 3 🔀 Widowed 4 ☐ Divorce	If Yes G	2 XNo	1	if Yas, specify Cu 1 ☐ Yes 2 🕱 No		gin? (Specify Yes , Puerto Rican, el	c.)	Bleck, White	
5-0	72 ho	ted	15. Decede	ent's Education rest grade complated	1	16e. Deced	dent's Usuel Occi	upation	of working	16b. K	ind of Businass/	Industry
21215-0020	filed within Hygiene. ther than "	Completed	Elamantary/Secondary (0-12		(1-4or 5+)	lifa.	kind of work don DO NOT use retir Homema		or working		Home	
	Hygin Hygin	Be Co	17. Fathar's Name (First, Middl	a, Last)			Tromema	1	r's Name (First, A	fiddle, Malden	117.555	5
lan	should be find Mental I	To B	Sa	amuel G.	Curry				Lott	ie Isac	dore Ell	iott
Maryland	2 shou and M is mar	-	19e. Informant's Name/Relatio	nship (Type, Print)	aughter	19b. Mailir	ng Address (Stree	et end Numbe	r or Rural Route	Vumber, City o	or Town, State, 2	Zip Code)
	1 and 2 Health a em 27 is		Mrs. Janet E.			4004	Ady R	oad, P	ylesville	, MD	21132	
ore	other other		20e. Method of Disposition		COL	ace of Dispo	sition (Neme of matory or other pi	ace)	Date	20c. Lo	ocation - City or	Town, Stata
E	Pages nent of I int: if ite		1 ⊠ Bunal 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other		State		,	,	n. 7/1/9	7 Be	Air. N	Maryland
Baltimore,	permit. Pag Department Important: I eny Injury o once.		21. Signature of Funaral Service	e Licens	2		2. Name end Add	ress of Fecility	h Funer	al Hom		
			23e. Pert1. Entar the diseasa, shock, or haert feilure. Li	or complications that	ceused tha death.	Do not ent					70-3197	Approximete
	Physician /Medical Examiner		Immediate Causa (Final disease or condition	•	eech line. DGK1258						2	Approximete Intervel Between Onsat and Death
	Lxammer	Je	resulting In death)	_	Due to (or	es e consec	quance of):					140000
	uted d ansit	Examiner	Convention to the tipe	b. E/	MPHY 8	es a consec					- 1	YEM
oʻ	icate be executed physician and s the burial-transit		Sequentielly list conditions, if eny, leading to Immediate ceuse. Entar Undarlying Cause (Disease or Injury that Initieted events	0	VEUMOR		juanos on.					7 DAVS
68760,	ysick ysick	ical	Cause (Disease or Injury thet Initiated events	С.		as a conseq	uence of):					1 20.12
	certificate be executed ding physician and use as the burial-transit	/Medical	resulting in deeth) Last	C)	PONIC			FA	1 LUR	2	j	? DAYC
Box	attend for us	lan/		d								
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0	res that the death signed by the atten i be detached for u	by Ph	LUNG CA	NIER	, ABD.	DMI	NAL	PATI	N	1 ☐ Yes 2	□ No 3 NP	robabty 4 🗆 Unknow
of Vital Records,	been	Completed	LUNG CA	4L A01	RTIC	AN	EURY	SM	24a	Wes en autop performed?	,	Were eutopsy findings availabla prior to completion of ceuse of death?
<u>~</u>	The law ate has page 2	E O	PNEUMO	THORK	7×					1 Yes 2	□No	1 ☐ Yes 2 🕱 No
/ita	Physicien: The raths certificate and director, page	Be (	25. Was cese referred to medic exeminar?		1			26. Plece	of Deeth (Check	only ona)		
5	0 0	P_	1 Yas 2 No	Hospital:	Inpatient 2 E	R/Outpetien	t 3□ DOA O	ther: 4 Nur	rsing Home 5	Residence	6 □Othar (Spe	cify)
	D e	ation:	27. Menner of Daath  1. Naturel 5 Pano 2 Accident inves	ing 28a. Date (Mortigation	of Injury oth, Day Year)	28b. Time of Injury	W	uryet ork? ]Yes 21⊠N		cribe how injur	ry occurred	
Division	or Attending after death. Director: Afte in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could	mined 200. FIEC	e of Injury - At hon ling, atc. (Spacify)	na, farm, str	eet, factory, office	•	28f. Loca City	tion (Street en or Town, State	nd Number or Ru	ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	edicai Ce	29a. Cartifiar (Check only one)  Certify  Certify  Certify	ing Phyalcian: To the	a bast of my knowledges of examinetic	ledge, daeth on end/or inv	occurred at that vastigation, in my	tima, data end oplnion, deetl	d plece, end dua t h occurred et tha	o the causa(s) time, date and	and mannar as d place, end due	s steted. to the ceusa(s)
	ro the	Me	29b. Signature and title of certif				29c. Licar	nse number		29d. Da	ta signed (Monti	h, Day, Year)
}	->-0		Kalshar	my	- m	D.	D	31850	6	6,	1291-	97
	$\infty$		30. Name and eddress of perso  D · SHARM	n who complated ceu	se of death (Itam 2	23a) (Type, AIR	Print)	FALL	STON	am	2104	47
			21 Date filed (Manth I Man) Ven	1 100= 001	Charles .	40	0.0					



State of Maryland / Department of Health and Mental Hygiene Q 7

211.82

			ITEM#18 PER F.H. FLM#	G749 7/22/97 J.A.	Ce	rtificate of	Death		Reg. No.		C 14	02
			1. Decedant's Name (First, Middle, La	ist)				2. Dete of D	Deeth		3. Tima o	of Death
	Physic		Kallion			GION	· KAS	Month	Dey	Yaer	100	50 pu
	/Medi		4a. Fecility Neme (If not institution, give					or Location of Dec	eth 4c. County	of Dooth	10	- Na
A.	Examir	ner	Carriage Hills N									
Н					Anna frinti da il	If Under 1 Yaar		Spring		gomer	-	
L	Funeral Director		577-50-7693	Sex 7. Age (In yrs 1□M 2☑F 90	: last birthday) Yrs.	Months Deys	Hours M	in (Month, I	6, 1907	9. Birthpl Count Gree		or Foreign
	pu »		Usual Residence of Decedent  10e. Stete 10b. County	100 0	ity, Town or Lo	anation.						<b>6</b> 2 11 2
	aryle the	_			ity, Town or Lo	ocation				10	Od. Inside (	
	Sa-f	cto	Maryland Montgom	nery C	hevy Cl	nase					1 L Ye	s 2 🙀 No
	# 50 M	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Whet Coun	try?	
	th w 23s		3201 Winnett Road	1		20815			USA			
	dea	Funeral	11. Meritel Status	12. Wes Decedant Evar in I Armed Forces?		Wes Decedent of H	lispanic Orlgin?	(Specify Yes or N		e - America		
0	or ite		1 Never Married 2 Married	1 ☐ Yes 2 🖾 No		If Yes, specify Cub		erto Mican, etc.)		ck, White, e	31C.	
05	alt, c	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Yeer or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify	Whi	te	
21215-0020	filed within 72 hours after death with the Marylend Hygiena ther than "natural", or items 23s or 28s-f show ent, the Medical Examiner must be notified at	Completed	15. Decedent's E	ducetion	16a. Dece	dent's Usuel Occup	etion	un mis in m	16b. Kind of B	usiness/inc	Justry	
21	hin 's	pie	(Specify only highest gra Elementery/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire	during most of w	rorking				
21	filad within Hygiena. other than	no.	12			Salespers	on		Re	tail		
b	0 - 0 >	Be	17. Father's Nema (First, Middle, Last	)			18. Mother's N	eme (First, Middi	la, Maiden Suman	10)		
<u>a</u>	lid be fentei ked o	ToE	Demetrios Sangos	}			Demet	ra Blaka	e PLAKA	AS		
Maryland	2 should be f send Mentei H is marked of raumatic eve		19e. Informant's Neme/Relationship (		19b. Meili	ng Address (Streat				State, Zip	Code)	
	od 2 lith e 27 is		George James Gia	nakos / Son	3201	Winnett	Road, Cl	hevv Cha	se. Marv	land	20815	5
ē,	ten ten othe		20e. Method of Disposition		Place of Dispo	osition (Name of		Date	20c. Location -			
Baltimore,	age ant o t: if i		1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 5)	Removel from State	-	matory or other place L1 Cemete	•	6/20/07	0	1 1/	1	,
壹	it. P		21. Signature of Funeral San			2. Name and Addre			Suitland			id
Ba	permit. Pages 1 and 2 should be Department of Heelth and Mente Important: if Item 27 is marked any injury or other traumatic and once.		21. Signature of 1 diferal Saration	Г И	2.			shire Av		ziai .	поше	
_			( budy	ud 6		Silver	Spring,	Marylan	d 20904			
ш		(	23 Part1. Enter the disease, con shock, or heart feilure. Unit only	plications that caused the dec one ceuse on each line.	th. Do not en	ter the mode of dyir	ng, such as card	iac or raspiratory	arrest,		Approxime Intervel Be	ete etwaen
	Physician						~		, , ,		Onset end	Death
	/Medical Examiner		Immediete Ceuse (Final disease or condition	a cut	- W	y o ce	ude.	2 mg	· Der	0-	300	m
	-xuiiiiiiiii		resulting In death)	Due to	or es e conse							
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	eath certificata ba axecuted ettanding physicien end I for use es the burial-transit	Examiner	Sequentially list conditions,	Due to (	or as e conse	quence of):						
68760,	a axi		Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disaase or injury							1		
876	ata b hysic	edicai	that initiated events resulting in deeth) Lest	Dua to (	or es e consec	quanca of):				1		
9	ng p	Med								ŀ		
XOX	th ce andi	an/		d								
œ.	the ettern	Physician/	Part II. Other algnificant conditions of	contributing to death but not re	sulting in tha u	inderlying ceuse giv	en in Pert I.	23b. Die	d tobacco uee co	ntribute to	the cause	of death?
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Vital Records,	requiras een sign hould be	b			4				s en eutopsy		ere eutopsy	
S	> D 0	jet						per	formed?	cor	ailabla prior mpletion of death?	cause
Be	The law ate has b page 2 s	Completed										
B			Or Manager and American						Yes 2 No	11	Yes 2	No
	Physician: this certific ral director,	Be c	25. Wes cese referred to medical exeminer?	Hospital:	_	Oth		eeth (Check only				
ō	Phys this rat di	٦.	27. Menner of Death	1 ☐ Inpatient 2 ☐	28b. Tima o	nt 3LI DOA	4 Nursing	1	sidence 6 Oth		()	
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State of Maryland / Department of Health and Mental Hygiene 97

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							Cer	tificate of	f Dea	th		Reg. No.		41100
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	/Medi		4a. Facility Name (If not institut		umber)				4b. City	. Town, or	Location of Deat		County of Deal	12:45pm
	Exami	ner	11504 West						′					
-			5. Social Sacurity Number	6. Sax	_	n yrs. lest birt	thdayl	If Undar 1 Yaa		dar 24 Hrs	8. Data of Bi		.G.	thpleca (Steta or Foraign
т	Funeral		075-18-9188	1 M 2 F		*	Yrs.	Months Day			(Month, De	ey, Year)	Co	ountry)
	Director		Usuel Residence of Decedent	Λ_	98						9/29/	1889	We	st Indies
	pue *		10e. State 10b. Coun	ty	10	c. City, Town	n or Loc	ation						10d. Inside City Limits
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	or tra		Rhonda Wils	on		11	504	West	Bra	nch	Dr.Lar	ao M	d. 207	7.4
ē,	othe othe		20a. Method of Disposition		2	20b. Pleca of	Dispos	sition (Name of			Dete	20c. Loc	ation - City or	Town, Stata
JO L	age onto y or		Burlel 2 Cramation	3 Removel from	n Stata .			on ceme		\ \7	7/1/97	Fari	mingda York	ale,
Baltimore,	it. P		21. Signature of Funerel Sarvio					Name end Add		-	Hodges			
Ba	permit. Pages 1 end 2 Department of Heelth e Important: If Item 27 is any injury or other tra once.		1 12 : 115	~ M . ~	1	,								
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of Vital		0	1 ☐ Yas 2 ☑ No	Hospital: 1	Inpatient	2 ER/Out	tpatient	3□ DOA C	other: 4	Nursing I	loma 5 PAes	dence 8	□Other (Spe	cify)
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Division	or Attendii efter deeth. Director: A I in by the fu	ific	3 ☐ Sulcide 6 ☐ Could deter	mined 289. Plac	e of Injury	At home, fai	rm, stra	at, factory, office	ө		28f. Location	Street end	Number or Ri	ural Route Number,
O	o effection	Certification:	4 LI HOMICIGO	Dull	ding, etc. (S	рөспу)					City of 10	wn, Stete)		
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	(2)		30. Name and address of perso	RI N V F	use of deeth	(item 23e) (	Type, F	Merc		1.1-	P	C	6	famo un
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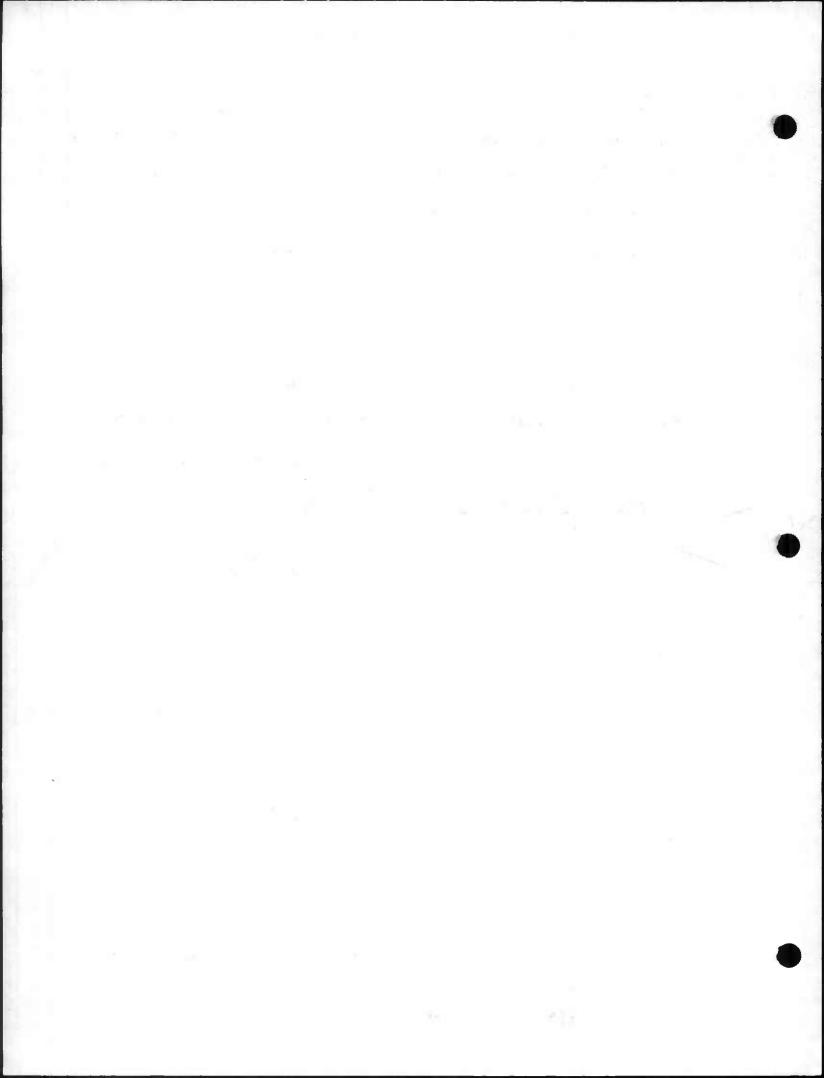
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	and * -		Usual Residence of Decedent  10e. Stete 10b. County		10c. City.	Town or Locati	on				10d I	Inside City Limits
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	286-	Director	Maryland Prince Geo:	rge's		Mitche	Of. Zip Code			10g. Citizen of V		
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	death ms 2:	Funeral	11. Marital Status	12. Wes Decedent	Ever in U,S.	13. Wes	20721 Decedent o		pecify Yes or No	Uni - 14. Rac	e - American Ir	ndian,
21215-0020	s 1 and 2 should be filed within 72 hours efter death with the Meryland if Health end Mental Hygiena. Item 27 is marked other than "neturel; or items 23a or 28a-f show other treumatic event, the Medical Experient must be notified at	b	1 ☐ Never Merried 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:	No			f Hispenic Origin? (Suben, Mexican, Puerl Specify:	o Rican, etc.)	Specify	ck, White, etc. v: B1 &	ıck
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	ges 1 and 2 t of Health If Item 27 i		Vassar D. Gibso: 20a. Method of Disposition	n - Daught		44 53rd	l Stre	et, S.E.,	Washingt Date	on, D.C	. 2001	9
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Baltimore,	permit. Peg Dapartment Important: Is any injury o		4 □ Donation 5 □ Other (Specify		Li			al Cemete:	ry	Suitlan	d, MD	
Ba	permit. P Dapartme Importan any injur		21. Signature of Funeral Service Licen:	L 4				fress of Fecility FUNERAL HO	OME. INC			
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			23a Anti. Enter the diseese, or comp hock, or heert feilure. List only of	lications that caused one cause on eech li	the death. ne.	Do not enter th	e mode of d	ying, such es cardiad	or respiratory e	rrest,	Apr	proximete ervel Between
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Division	i Di afte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injuding, etc.		e, ferm, street,	factory, offic	е	28f. Location ( City or To	Street end Numb vn, State)	per or Rurel Ro	ute Number,
	the Hospital in 24 hours the Funeral	edical	29a. Certifier (Check only one) 1 ★ Certifying Phyone) 2 ★ Medical Example 1 ★ Certifying Phyone 1 ★ Certifyi	rsicien: To the best of iner: On the basis of and menner sta	examination	edge, deeth occ n end/or investi	curred at the gation, in my	time, dete end plece opinion, deeth occu	, end due to the rred et the time,	cause(s) end me date and place,	enner es steted end due to the	l. ceuse(s)
	9 2 2 8	Σ	29b. Signature end title of certifier	. 1			29c. Lice	nse number		29d. Dete signe	d (Month, Dey,	Year)
1	11.		Mary Ruc	LM. Vap	X		1	D46834		Julu	1, 199	7
(	9		30. Name end eddress of person who o	ompleted cause of d	eeth (Item 2	3e) (Type, Prin				- 0009		
			Mary Ruth Lopez.	MD 7243	B Han	over Pa	rkway	Greenbel	t, MD	20770		

State Registrar free of the second of the seco

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** Anne E. Mc Gonina 6 97 L:00 9x /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Bowie Prince George's Larkin-Chase Nursing Home 8. Date of Birth (Month, Day, Year) March 23, 1903 9. Birthplece (Stete or Foreign Country) Pennsylvania 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 7. Aga (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) **Funeral** Deys 1□M 2□F 94 163-24-8565 Vrs Director Usual Residence of Decedant Pages 1 end 2 should be filed within 72 hours efter death with the Meryland ment of Health end Mental Hygiene.

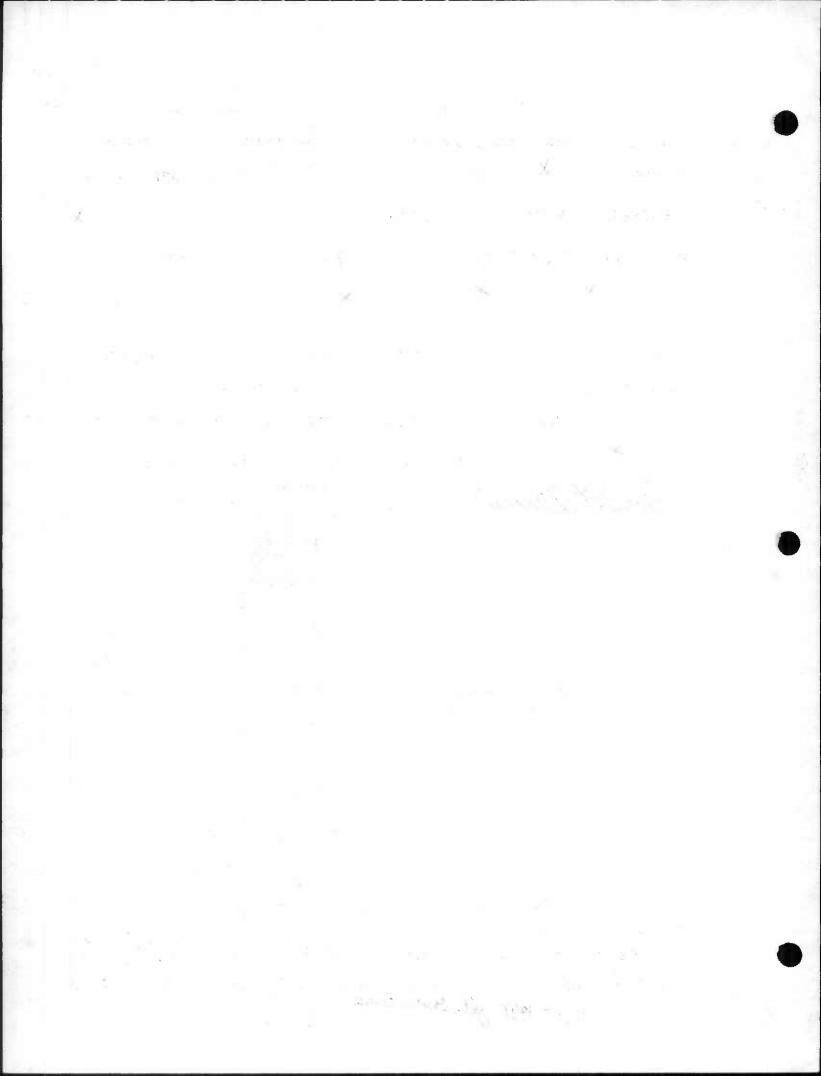
The first of terms and other than "natural", or items 23a or 28e4 show that it are 27 is marked other than "natural", or items 23a or 28e4 show any or other traumatic event, the Medical Experies must be notified at 10e Stete 10b. Count 10c. City, Town or Location 10d. Insida City Limits Maryland Prince George's Bowie 1 Kryes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? 12526 Knowledge Lane 20715 United States Funeral 12. Wes Decadent Evar In U,S. Armed Forces? 14. Race - American Indien, Was Dacadent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) Bleck, White, etc. 1 Navar Married 2 Married 1 ☐ Yes 2XXIIIo If Yes, Give Yaar or Detes: Baltimore, Maryland 21215-0020 1 Yas ZKNO þ Specify: 3√Widowed 4 Divorcad White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Francis Dinsmore Katherine Ward 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Ann E. Lamb Daughter 12526 Knowledge Lane Bowie Maryland 20715 Department of Health Important: If Nam 27 any Injury or other tr page. 20e. Method of Disposition
1 □ Buriel 2 □ Cremation 3 □ Removel from State 20b. Pleca of Disposition (Name of cametery, cremetory or other plece) Deta 20c. Location - City or Town, Steta 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory July 3, 1997 Alexandria Virginia 22. Name and Addrass of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715 complications that caused tha daath. Do not enter the mode of dying, such as cardiac or respiretory errest only one cause on each line. **Physician** Immediate Ceuse (Finel disease or condition resulting In deeth) /Medical Cardia jepith Examiner Due to (or es e consequenca of): Physician/Medical Examiner physician end s the buriel-trensit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) P.O. Box 68760. Dua to (or as e consequenca of): 98 USB signed by the et d be deteched fo Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Ware eutopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed page 2 s 1 Yes ₽₽No 1 Tyas 2 THO or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 | Yes 2 | 1√0 Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manney of Death 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 1 Naturel 5 Pending investigation efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined To the Hospital or Attar within 24 hours efter der To the Funeral Directo completely filled in by th 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edical 29a. Certifier 12 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end pieca, end due to the ceuse(s) end manner es steted. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred at tha tima, dete and placa, end dua to the ceuse(s) end manner stated. 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 323/ Superio (Jobin, nD 39. Registrer's Signetura 31. Data filed (Month, Dey, Yeer) State

**DHMH 16 Rev 6/9**5



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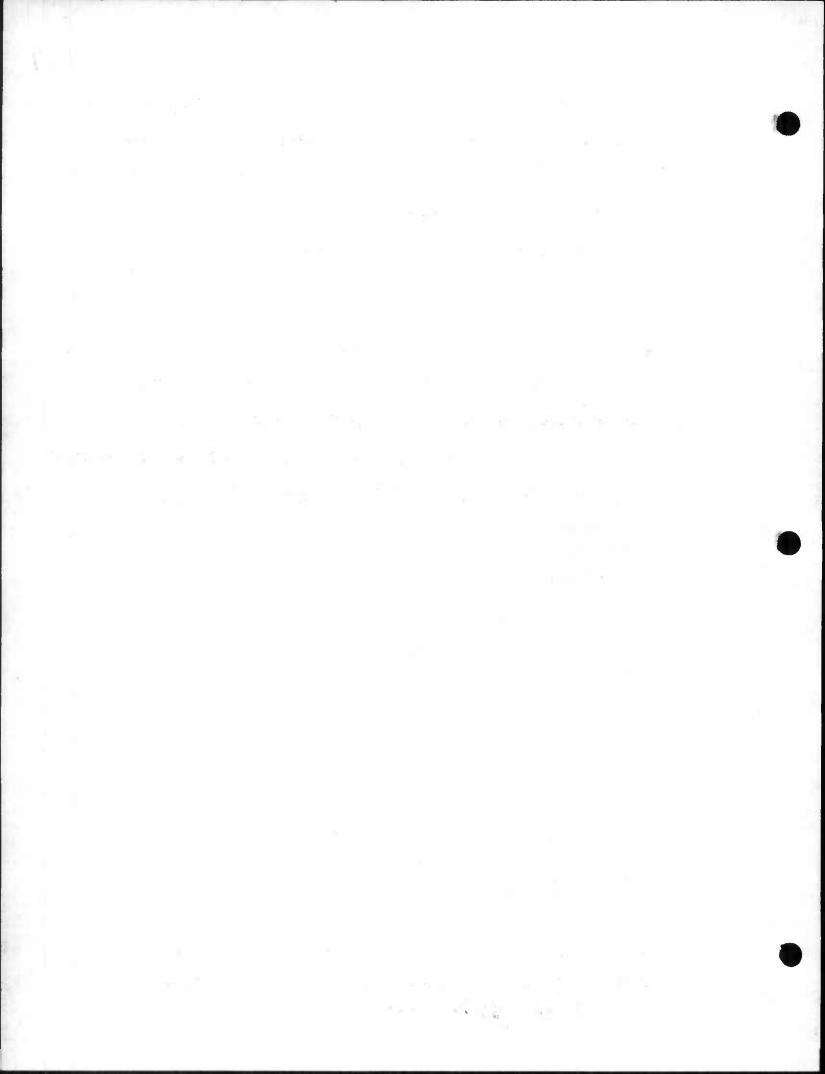
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uneral rector		217-49-8730 Usual Rasidance of Decedant	MA OF E	59	Yrs.	Months			lin. (M	ta of Birth orith, Day, / 16/		9. Birthp Cour KOR	elaca (Stata or etry) EA
<b>₹</b> 11	-	10a. Stata 10b. County		10c. Ci	ty, Town or Loc	cation						1	0d. Insida City
or 28a-f show	0	MARYLAND TO WICOM	ICO	S	ALISBUF	RY.							1 Yas
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State of Maryland / Department of Health and Mental Hygiene

21487 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month DANIEZ HORNER /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester General Hospital Cambridge Dorchester 6. Sex/ 173 M 2□ F It Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) **Funeral** Days Hours Yrs June 27 1920 Maryland Director 217-10-8928 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "neturel", or items 23e or 28a-f show treumstic event, the Madical Examinar maint be notified at MD Dorchester Cambridge 12 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? nit. Pages 1 and 2 should be filed within 72 hours after death with is artment of Hatilth and Martiel Hygiana. ortant: If item 27 is marked other than Inetural; or items 23e or ? Injury or other traumatic event, the Martinal Traintier mail to 405 Robbins St. 21613 U.S.A. by Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ blever Married 2 ☐ Married 1 Yes ZY No It Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 1□ Yes ZUNO White 8 Widowed 4 □ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) truck driver chemical production 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be William James Horner Emma Wesley Sinclair 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Deborah Faulkner-daughter 3659 Karen Circle, Linkwood MD 21835 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State Dapartment of Important: If any injury or once. Dorchester Memorial Park | 7-3-97 | Cambridge, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Thomas Funeral Home PA STAR Thomas 700 Locust St. Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Congahire Heur **Examiner** Examiner perteun The law requires that the death cartificate be axecuted bunal-transit Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence ot): Box 68760. attanding physiclan Physician/Medical tha Due to (or es a consequence of): ata has been signed by the attanding p paga 2 should be datached for usa as Part II. Other significant conditione contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No .3 Probably 4 Unknown þ Completed 24a. Was en eutopsy performed? 24b. Were autopsy findings completion of ceuse of death? Aftar this cartificata 1 🗆 Yes 2 100 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 201No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA funeral 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation Netural 1 ☐ Yes 2 ☐ No death 2 ☐ Accident after death Director: 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) in by 4 Homicide 24 hours a 1€ Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, and due to the cause(s) and manner as stated.

2 ■ Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) end manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signetu/e and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) menta 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) VINODRAI MEHTA 300 AURORA STREET CAMBRIDGE, MD 21613 31. Date tiled (Month, Day, Year) 32. Registrar's Signeture State JUL 7 Davideor nardalle Registrar



# Hornick John Morris Baltimore, Maryland 21215-0020

**Physic** /Medi Exami

**Funeral** 

Director

permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mantel Hygiene. Important: If item 27 is merked other than "natural", or items 23s or 28a-f show any injury or other traumatic evant, it a Medical Exercited rives to notified at once.

**Physician** /Medical Examiner

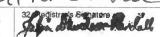
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Division of Vital Records, P.O. Box 68760,	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the bunal-tensit	

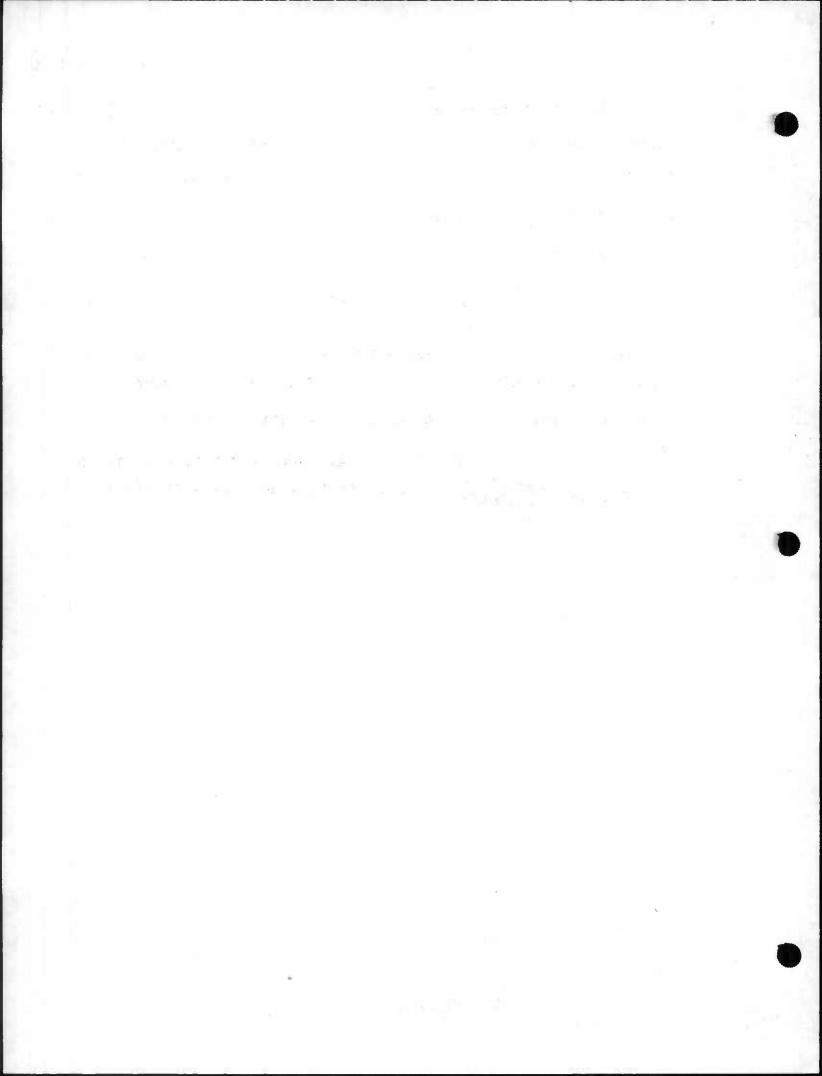
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irec	10e. Street end Number	er .				10f. Zip Co	de				10g. Citizen of	What Cou	ntry?	
a D	161 Me	adow '	Trai1				17	314			U	SA		
Completed by Funeral Director	11. Marital Status		12. Was Decede	ent Evar in U,S	. 13. V	Vas Decedent Yes, specify	of His Cuban	panic Orlgin Mexican, F	n? (Spe	cify Yes or No-		ca - Ameri ck, White,		ın,
F	1 Never Married		XXYes 2	□No		☐ Yes 2 🔀		Specify:	20.10	110411, 010.7		.Whi		
Q P	3 ☐ Widowed 4 Ē		Year or Dete	es: WW 2										
iete	(Specify		Education rede completed)		16e. Deced (Give I	lent's Usuei O kind of work d DO NOT use re	ccupat one du etired)	ion I <i>ri</i> ng most o	f workin	g	16b. Kind of B	usiness/Ir	dustry	
mo	Elementary/Seconds unknown	ary (0-12)	College (1-4			Driv					Agric	11 1 11	ro	
Be C	17. Father's Nama (Fin						1	-			Maiden Sumer	ne)	120	
ToB	Leonard	C.	Hornick				1	Winif	fre	d L.	Ivin	S		
	19a. Informent's Name						-				r, City or Town	Stete, Zi	p Code)	
	Richard		rnick					, Del	Lta	, PA 17	314			
	20a. Method of Disposi		☐Removal from Sta	0.00	metery, crem	sition (Neme of netory or other	r plece			Dete	20c. Location			
	4 Donetion 5 [	Other (Spec	eify)	St.					7/	5/97 E	ylesv	ille	, M	D
	21. Signeture of Funer	al Servica Lice	ensee	11		Name end A			nc.	,Delta	,PA 1	7314		
	1/elm	D.	filler	7										
	23a Part . Enter the d	disaasa, or con ailure. List onl	mpilcetions thet cau y one cause on eec	sed tha death. h line.	Do not ente	er the mode of	dying	such dis ca	ırdiac o	r raspiratory ar	rast,	İ		rimate I Between end Death
	Immediata Causa (Fin	ai			C.1 3	1		1	Const.	4020000	1.			
	diseese or condition resulting in death)		Chw		220m	wy	~	Jul	mu	ncey	Jula	u	34	eer
ner				Dua to (or a	as e conseq	uence or):	(	)				1		
dical Examiner	Sequentially list condit	ions,	b	Due to (or a	as e consequ	uence of):								
EX	Sequentially list condit if eny, leeding to imma cause. Enter Underlyi Ceuse (Diseese or inju	ndiate										į		
dica	thet initieted events rasulting in death) Last		C	Due to (or e	es e consequ	uence of):								
Me		·	l d											
Completed by Physician/Me														
ysi	Pert II. Other significan	nt conditions	contributing to deat	h but not result	ing in the un	derlying caus	e giver	n in Pert I.		\_	obacco uee co			
y Pt	Cowv	rav	7 cm	lery	au	nai	_		_	X	res 2□ No	3 Pro	Dabiy	4 Unknown
q pa		(								24a. Was	an eutopsy		ere euto	psy findings
piet				,	11				_	репо	mad?	CC		of cause
mo:	†									1 🗆 Y	as 2 No	1	□Yas	2110
Be C	25. Wes case referred exeminer?	to medicai	1-0					26. Plece of	Deeth	(Check only o	ne)			
To	1 Yes 22 No		Hospital:	atient 2 E	R/Outpetient	3□ DOA	Other	. 4 ☐ Nursi	ing Hon	ne 5 🗆 Resid	enca 6 □Oth	er (Speci	ify)	
on:	27. Manner of Deeth	Pending	28e. Date of I (Month,	njury Dey Year) 2	28b. Time of Injury		Injury (			8d. Describe h	ow Injury occur	red		
icati	2 Accident 3 Sulcide 6	investigation Could not	be co. Di	1				es 2 No		06 1 10 10			-10	Marka
ertif	4 ☐ Homicide	determine	d 28e. Place of building,	Injury - At hom etc. (Specify)	ie, ierm, stre	et, factory, of	TICE		2	City or Tow	treet end Numb n, Stete)	oer or Hur	ai Houre	Number,
Medical Certification:	(Check only	Certifying P	hyelcian: To the be	s of examinatio	edge, death on end/or inv	occurred et the	ne time	, dete end p	olace, e	nd due to the o	ause(s) end m	enner es s	stated.	use(s)
Mec	29b. Signature and ritle	of certifier	end manner	stated.	)	29c. Lie	censa	number			d. Date signe	d (Month	Day, Ye	ar)
	1 20	rclo	- re	11.1		-	02	183.	30	1	July	1, 1	99	7
	30. Neme end eddress	ME 1		of deeth (Item 2	(Type, E	Print) Nos	nd	Re.	la	uMo	201	5		

18x1 State Registrar

31. Date filed (Month, Day, Year) 3 1997 JUL





State of Maryland / Department of Health and Mental Hygiene

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/Medica Examine

Funeral Director

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-4 show sny injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours aftar death.

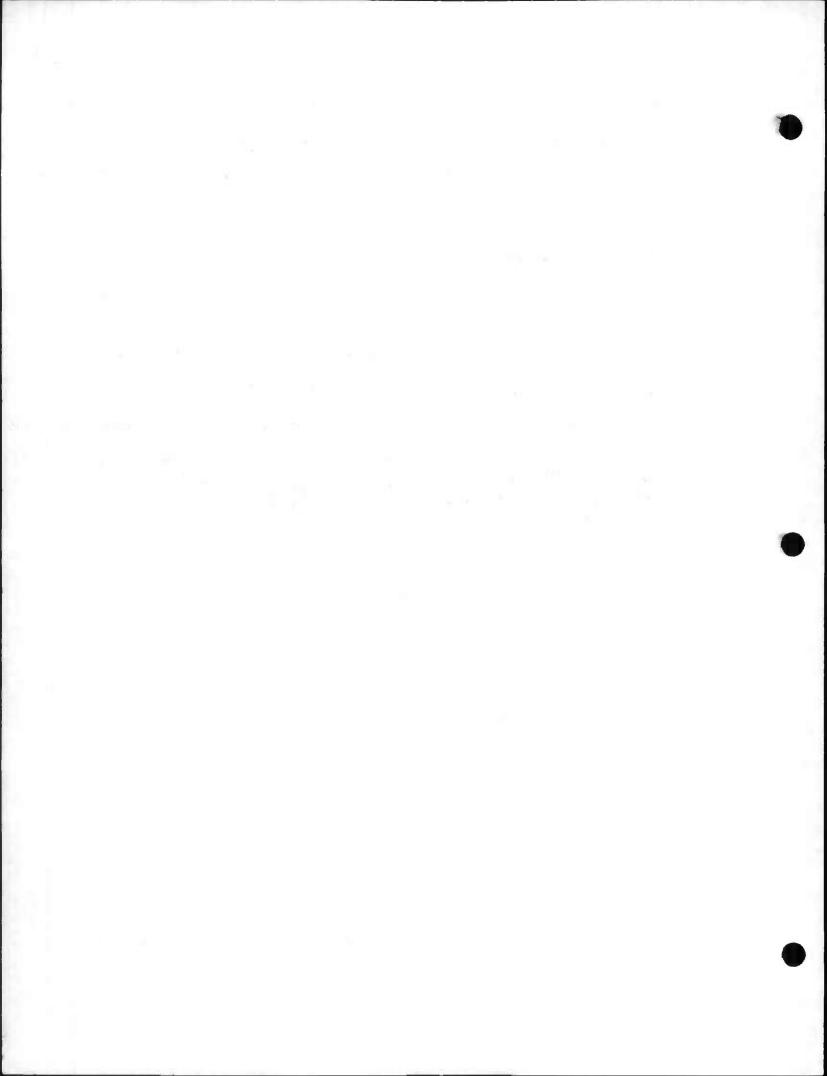
To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, pege 2 should be detached for use as the buriel-transit Division of Vital Records, P.O. Box 68760,

			naryiana / L	Certificat				Reg. No.	21	21409
-	1. Decedent's Name (First, Middle, La	ist)					2. Date of		Vone	3. Time of Deeth
an cal	Olga J. Halesky						JUNE	2 <sup>Day</sup> ,	19 <sup>9</sup> 7	11:54 AM
ner	4a. Facility Nama (If not institution, given	a street and numbe	r)			b. City, Town,	or Location of De	ath 4c. Coun	ty of Death	118
	SUBURBAN HOS	PITAL				BETHE	SDA	MON	TGOME	RY
Г	5. Social Sacurity Number 6. S	Sex · 7.7	Age (In yrs. last bin	thday) If Under		If Undar 24 H	irs. 8. Date of			place (Stata or Foreign ntry)
	217-70-7813	1□M 2⊠F	83	Yrs. Months	Days	Hours M	Nov. 29	. 1913		sylvania
	Usual Residence of Decedent						710.002	, -, -,	JE CITTLE	2) I Vanila
_	10a. State 10b. County		10c. City, Towr	n or Location						10d. Inside City Limits
cto	Maryland Montgor	nerv	Si	ilver Sp	ring					1 ☐ Yes 2万 No
ire	10e. Street and Number			10f. Zip				10g. Citizen o	f What Cou	ntry?
<u>=</u>	3557 South Leisur	re World 1	81vd #2F	7 20	0906			U.S	٨	
Funeral Director	11. Marital Status	12. Was Deceder Armed Forces		_		ispanic Origin?	(Specify Yes or lerto Rican, etc.)		ace - Amari	can Indian,
2	1 ☐ Never Married 2 ☐ Married	1 ☐ Yas 2 ☐					erto Rican, etc.)	BI	ack, White,	etc.
b	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates		1 ☐ Yes	2IXI No	Specify:		Spec		hite
Completed	15. Decedent's E	ducation	16a.	Decedent's Usua	al Occup	ation		16b. Kind of		
pie	(Specify only highast gra Elementery/Secondery (0-12)	ade completed) College (1-4o		(Give kind of wor life. DO NOT us	rk done se retired	du <i>ring</i> most of a f)	working			
0	12	Conege (1-40)		memaker				Own H	OMA	
Be C	17. Father's Nama (First, Middle, Last	)	110	memarei		18. Mother's N	Name (First, Midd			
ToB	John Javornis	ek v				Anna	Gurni	11-		
-	19a. Informant's Name/Relationship (		19b.	. Mailing Address	(Street				n State Zir	n Code)
	Elaine H. McArd	Le	20b. Placa of	Disposition (Nan	Le C	rown Ro	ad Darr	20c. Location	Maryl	and 20878
	1 Burial 2 Cremation 3 □		Θ .	y, cramatory or o		•				
	4 Donation 5 Other (Specif		Parkla	wn Memor			06/28/97	Rockvi	lle,M	aryland
	21. Signature of Funeral Service Lice	nsee 1	1.	22. Name an			s Funera	1 Home	Tnc	
	7. Keum	· Juto	ruski							,MD 20901
-	23a. Part1. Enter the diseasa, or com shock, or heart failure. List only	plications that cause	ed the death. Do n	not anter the mod	e of dyir	g, such as card	liac or respiratory	arrast,		Approximate Interval Between
										Onset end Deeth
	Immediate Causa (Final disease or condition	u	MPUS	Tall:	ME	5				
	resulting in death)	θ.	Due to (or as a c							
Examiner		<b>b</b>							1	
am	Sequentially list conditions,	D	Due to (or as a c	consequence of):						
	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying								1	
edical	Cause (Disease or injury that Initiated events resulting In death) Last	С.	Due to (or as a c	onsequance of):					1	
an/		d							1	
sicl	Part II. Other algnificant conditions of	ontributing to death	but not rasulting In	the underlying ca	ausa giv	en In Part I.	23b. Di	d tobacco use c	ontribute t	o the cause of death?
Phy							10	Yes 2□No	3 □ Pro	bably 4 Unknown
by I										
B								as an autopsy rformed?	24b. W	ere autopsy findings vailable prior to
Completed by Physician/M							-   Pe		CC	ompletion of causa deeth?
E							V.	Yes 2 No	1%	er 2□ No
Be C	25. Was case referred to medical					26 Place of F	Deeth (Check onl			3.00 22.00
To B	exeminer? 1X Yes 2 No	Hospital:	ient 2X EB/Out	tpatient 3 DO	Oth	O.C.	g Home 5□ Re	1	ther (Special	6/1
n: T	27. Menner of Death	28a. Date of In	ury 28b. T		8c. Injur Wor			e how injury occi		NOTHER COR
얉	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	n 6 7 il	C - 1	njury		k? Yes 21⊠No	Deiver	1. DECAG		4PACTWITH
fica	3 ☐ Suicide 6 ☐ Could not b		njury - At home, far		. offica		28f. Location	(Street and Nun	-	al Route Number,
ert	4 Homicide determined	building,	Copecify)				City or T	own, State)		
Medical Certification:	29a. Certifier 1☐ Certifying Ph	ysicien: To the bes	0		at the tin	ne date and cin				and Andra Cohb
dica		niner: On the besis and manner s	of examination and	for investigation,	In my o	pinion, death oc	curred at the tim	e, date and place	and due to	o the cause(s)
Me	29b. Signatura and title of certifier	and mained a		290	. Licans	number		29d. Date sign	ed (Month	Day, Year)
	1	Andle	1.	200			M.E.	JUNE 2		
	lagone	une you	a W	WI						
	30. Name and eddress of person who	A 1			O F		-144	ma 1/-	1 = ·	A 21201
	MALLYDOURS	13. 100RG		renn	str	eet, B	altimo:	re, Mar	уıan	d 21201
te	31. Data filed (Month, Day, Year)	1997 32. Regis	var's Signature	n-Randopa						
ar		1001								

State Registrar STORY STORY

State of Maryland / Department of Health and Mental Hygiene 97

					Cer	tificate	of l	Death		F	Reg. No.			
4 6 10		1. Dacadent's Name (First, Middle	, Last)							2. Data of Das	ith		3. Time of D	eath
Physic		GEORGE	PATRIC	K			HA	2 LEY		JULY	Day (	1997	0145	-
/Medi Examir		4a. Facility Name (If not institution,	, give street and numba	a <i>r</i> )			4	b. City, To	wn, or L	ocation of Death	T	y of Death		_
Examin	iei	Holy Cross Ho		,				C+1-	TOW (	Spring				
E				Age (In yrs. la	ast birthday)	If Undar 1	Yaar	If Under	24 Hrs.	8 Date of Birt	h MO	ntgom	lery	Foreign
Funeral Director		577-32-6128	1 <b>⊠</b> M 2□F	67	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Jan. 25	1930	Wash	intry)	ח
		Usual Rasidence of Decedent								oun. 23	, 1550	Wasii	iligion,	υ.
B 11		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City	Limits
and and	ŏ	Maryland Montgo	omerv	Si	lver S	nring							1 ☐ Yas 2	2 2 No
284	Directo	10e. Street and Numbar		D1.	LVCI D	10f. Zip C	`nda				10g. Citizen of	What Cou	inter?	
remous and coom with the wayse tracked, or temporalized at another must be notified at				201								What Cou	iiitti y r	
osath with the Marysand ms 23a or 28a-f show r.must be notified at	Funeral	11616 Stewart L					904		1 0 10		USA			
S E I	Š	11. Marital Status	12. Was Decedar Armed Force	s?		vas Decede f Yes, specif	nt of Hi y Cuba	n, Mexicai	igin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)		Race - American Indian,     Black, White, etc.		
72 hours sher hatural', or its fical Examine	by F	1 Never Married 2 Marrie	If Yes, Give	-	1	Yes 2	No.	Specify:			Speci	fy:	Black	
I Par		3 Widowed 4 Divorced	Year or Dates	s:								<u> </u>	ьтаск	
wither 72 ho jens. r than "natur the Medical	Completed	15. Decedent' (Specify only highest	's Educetion it grade completed)		(Give	lent's Usual kind of work	done d	du <i>rina m</i> os	t of work	ring	16b. Kind of E	łusiness/ir	ndustry	
wither ens. then 1 he Mes	ďμ	Elamantary/Secondary (0-12)	Collaga (1-4c	or 5+)		OO NOT usa		•						
Hygier th	00	9			Dr	y Cle	ane				Dry C		ng	
0 = 0 =	æ	17. Father's Name (First, Middla, L						18. Moth	er's Nam	a (First, Middle,	Maiden Surna	ma)		
	2	George Patrick	Harley, Sr	•			i	Este	11e	P. Cann	on			
		19a. Informant's Name/Ralationsh	nip (Type, Print)		19b. Mailin	g Address (	Street	and Numb	er or Ru	al Route Numbe	r, City or Town	, Stata, Zi	p Code)	
and 2 saith a s 27 is ar fras		Gwendolyn C. Ha	rley / Wif	e	11616	Stew	art	Lane	. Ar	t. 301,	Silver	Spr	ing. MD	20
- 2 5 6		20a. Method of Disposition		20b. Pla	ace of Dispos	sition (Name	of of			Date	20c. Location			
0		1 Burial 2 Cramation		ta	matary, crem				į,	/5/97 Laurel, Maryland				
4 E E E		4 Donation 5 Other (Sp	-	rial					-				•	
Depa my II	_	4 Donation 5 Other (Spacify)  Maryland National Mem. 7/5/97 Laurel, Maryland  21. Signatur of Fungral Service Dicesses  22. Nama and Address of Facility Hines—Rinaldi Funeral Home  11800 New Hampshire Avenue												
/		1200	to Al		Ŝ	ilver	Spi	ing,	Mar	yland	20904			
-(	1	Part1. Enter the disease, or o shock, or heart failure. Date	mplications that cous	ed the death.	Do not ente	er the mode	of dyin	g, such as	cerdiac	or respiratory an	rest,	I	Approximate Interval Between	aon
hysician			,									l	Onset and De	
/Medical		Immediate Cause (Final disease or condition		SFR	710	SH	1/1					1	1 DAG	,
Examiner		resulting in death)	a		as a consaq								1011/	
	Je.			/1/.	uno							1	IDA.	
o p	Examiner	Water and the Water and Table	b	-	as a conseq	1	-						100/9	
noate be execut physician and is the burial-tran	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		וט) טו געם	as a conseq	derice ory.						Į		
entificate be executed by the physician are as the burial-b	edical	Cause (Disease or injury that initiated events	c	Due to /es								-		
of physical	ig	resulting in death) Last		Due to (or	as a consaqu	uence or):						1		
0 20 22	3		d											
for the	Physician				_									
6 6 6	ys	Part II. Other significant condition			_		use give	en in Part	l.				to the cause of	
ed by delac		KESPINAT	10 Ry HALL	LURE						101	es 2□No	3 Pro	obably 4 U	nknov
5 5 2	i by	11	TIC LUN							41/ 11/20	March Collin	T 045 V		ette en
been sign should be	Completed	METASTA	TIC Lun	16 4	Ances	2				24a. Was a	an autopsy med?	av	Vere autopsy fin vailabla prior to ompletion of cer	
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4 2	0.0									1 🗆 Y	es 2 No	1	☐ Yas 2☐ N	lo
	Be C	25. Was case referred to medical						26. Place	a of Deat	h (Check only o	ne)			
	0	examiner? 1√ai Yes 2 No	Hospital:	tient 2 5	R/Outpatien	t 3 DOA	Othe	ar.		me 5□Resid		har /Saac	(6 <sub>4</sub> )	
	12	27. Manner of Death	28a. Date of In	njury	28b. Time of		c. Injun Worl		and the	28d. Dascribe h			1197	
r death. actor: Alter by the fune	tion	1 Natural 5 ☐ Panding 2 ☐ Accident Investiga	9	Day Year)	Injury	М		<br Yes 2□	No					
desi desi	Eca	3 ☐ Suicide 6 ☐ Could no	ot be	loiun At bon	no form etro	not factory			-	28f. Location (S	Stroot and Num	her or Pu	ral Route Numbe	or.
after of Direct in by	Certification:	4 Homicida datarmir	building,	etc. (Specify)	, iaiiii, 5(le	Joi, laciory,	011100			City or Tow		- or riur		,
5 2 2		00 C-110												
within 24 hours after deall To the Funeral Director: completely filled in by the	edical	(Greek only 2 Medical E	g Physician: To the bas Examiner: On the basis	of examination	riedga, daath on and/or inv	occurred at estigation, in	the tim	na, data an pinion, daa	id place, ith occur	and due to tha c red at the time, o	ausa(s) and material and place.	annar as :	stated. to the cause(s)	
the side	Med	Oney	and manner	stated.										
100	-	29b. Signature and title of certifier	Maron			_		number			29d. Date sign			
6		Merendrall	4			0	501	12		2	THLY	01	1771	
132				f death (Item	23а) (Туре, І	Print)	-		0					
		UIRENDRA K-S.	AXENDA MAD 7	100 De	er Ch	ossing	Cor	est,	Bet	horin 1	s can	081)		
Sta	te	31. Date filed (Motific Pay 1 eg	1007 32. Rygi	strar's Signati	ure _									
Registr		AAF 0 3	1337 Sul	strar's Signatu	on-Rang	lell-								



State of Maryland / Department of Health and Mental Hygiene

21491 Certificate of Death

		-							neg. No.			
	Physic	ion	Decedent's Name (First, Middle, Last)		2. Date of De	ath Dey	Yeer	3. Time o	f Deeth			
	/Medi		Francis Alfred		Hurley	Jr.		June	30′ 19	97	12:01	. AM
	Exami		4e. Facility Neme (If not institution, give	street and number)			4b. City, Town, or	Location of Deeth	4c. County	of Deeth		
			10014 Tenbrook Dr	ive			Silver S	Spring	Montg	gomer	У	
	Funeral	Г	Sociel Security Number     6. Sex		yrs. last birthday	If Under 1 Ye Months De		8. Date of Birl (Month, Da	h		lece (State	or Foreign
8 1	Director		579-10-0987	M 2□F 81	Yrs.	Months De	ys Hours Min.	April	30, 1916	Was	hingt	on, D
2	>	1	Usuel Residence of Decedent  10a. Stete 10b. County	10-	0% T							
2	Show	_	10a. Stete 10b. County	100	. City, Town or L	ocation				11	Od. Inside C	
Med	Ba-f	ct	MD Montgome	ry S	ilver Sp	oring					1 L Yes	2 No
i di	0 o c	Director	10e. Street end Number			10f. Zip Cod			10g. Citizen of V	Vhat Coun	try?	
4	23		10014 Tenbrook Dr			209			USA			
ar do	1	Funeral		12. Was Decedent Ever i Armed Forces?	in U,S. 13.	Was Decedent of If Yes, specify C	of Hispanic Origin? (S Juban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	- 14. Race Blace	e - Americ k, White,		
d 21215-0020	than "natural", or items 23s or 28s-f show the Modical Evaniner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Ty Yes 2 □ No If Yes, Give		1 ☐ Yes 2 💢 N	No Specify:		Specify	Whi	ite	
Maryland 21215-0020	al E	D D			WII		100 a. (1)		101 10 1 10			
5 5	agic a	Completed	15. Decedent's Edu (Specify only highest grade	completed)	(Give	edent's Usuel Oc kind of work do DO NOT use rel	cupation ne during most of woi tired)	tking	16b. Kind of Bu	JSINess/Inc	lustry	
212	than than	E	Elementary/Secondary (0-12)	College (1-4or 5+)		iness Ow			Self E	īmn la	bov	
0	tal Hygiane. d other than event, the M		17. Fether's Name (First, Middle, Last)		Dabi	LIICOD OW	18. Mother's Nar	ne (First, Middle,			yeu	
<u>a</u>	a d s	To Be	Francis Alfred Hu	rlav			Ango 1 o	Herbert		,		
2	th and Men 7 is marke traumatic	F	19a. Informent's Name/Relationship (Ty)	-	19b Mail	ing Address (Str	eet and Number or Ru		er City or Town	State Zin	Code)	
, Mô	Ta la		Francis Alfred Hu				ive, Longw		32750	Ototo, Zip	0000)	
a .	7 5 5		20e. Method of Disposition			osition (Name of matory or other)		Date Date	20c. Location -	Clty or To	wn. Stete	
Pages	Int of		1 Burial 2 Cremation 3 R	emoval mom State				- 10 10-				
altimore,	nium nium		4 □ Donation 5 □ Other (Specify)  21. Signety of Funeral Service License		Metropo.	Litan Cr	ematory dress of Fecility Fr	7/2/97 I	Alexandr	cia,	VA	
מ פ	Department of important: If II any injury or once.		Z I. Signet of pri diletal service conse	<i>" ()</i>		ome, Inc		versity			Herar	
	_	_	Comosi	na	Si	llver Sp	ring, MD	20901				
		10	23a. Part1. Enter the disease, or compli- shock, or heert failure. List only on	e ceuse on each line.	Jeeth. Do not er	iter the mode or t	aying, such es cardiac	or respiretory er	rest,		Approxima Intervel Be Onset end	tween
	hysician Medical		Immediate Ceuse (Final		-1		i . 0		fact		-	DOU!!
Ε	xaminer		disease or condition resulting in death)	مد			iardía!	12	tac "	OW	15	nuy
Ш		je.			to (or es a conse	1				İ	40	
petra	d ansk	Examiner	Sequentially list conditions		to (or as e conse	hy So	ma			-	70	
D,	an an rial-tr		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	540 (	0 (0. 40 0 001150	quonoc en.						
OX 58/50,	igned by the ettending physician and be datechad for usa as tha burial-transit	an/Medical										
الله	ng ph as th	Ned Ned	resulting in death) Last							i		
Š Š	endii r usa	an/	d							1		
O death	ha et ad fo	Physici	Pert II. Other significant conditions con	tributing to death but not	resulting In the	underlying cause	given In Pert I.	23b. Did 1	obacco use cor	ntribute to	the ceuse	of death?
ords, P.O	d by that	P.						10	Yes 2 No	3 Prot	bably 4	Unknown
S th	b ed	by										
ecords,	been si	ted							en eutopsy rmed?	eve	ere eutopsy eilable prior	10
e 60	L (5)	ple									mpletion of o	cause
r e	ata h	Completed						101	res 2⊠No	10	Yes 2□	] No
Vital	is certificata diractor, pag	Be	25. Wes case referred to medical exeminer?				26. Plece of Dea	ath (Check only o	ne)			
OT VITA	this ce	2	Yes 2□ No H		2 ER/Outpatie	III JU DOA		ome 5 Resid	dence 6 □Oth	er (Specify	1)	
		00	27. Menner of Deeth  1. Neturel 5 □ Pending	28a. Dete of Injury (Month, Day Yea.	r) 28b. Time of Injury	of 28c. Ir	njury et Vork?	28d. Describe h	now injury occurr	red		
OIVISION or Attending	daath. ctor: A y the fu	cati	2 ☐ Accident investigation			M 1	Yes 2 No					
N A		Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, si ecify)	reet, factory, office	ce	28f. Location (5 City or Tox	Street and Numb vn, State)	er or Rure	I Route Nun	nber,
Jale C	rai D											
Hose	24 hours aftar daath Funeral Director: A ataly filled in by the f	edicai	(Check only 2 Medical Examin	ician: To the best of my er: On the besis of exem	knowledge, deal nination end/or Ir	th occurred et the evestigation, in m	e time, dete end place by opinion, death occu	, end due to the rred et the time,	ceuse(s) end me date end placa, e	enner as st end due to	eted. the ceuse(	s)
e di	within 24 hours after To the Funeral Dir complataly filled in	Med	29b. Signeture end title of certifier	end menner stated.			ense number		29d. Dete signed			
			200. Signoture end title of certifier	0	10-				Lau. Dele signet	a (morniri, t	Jay, rear)	109
10	41		at !	Jan	V		28544	5	June		>0	17
			30. Name and address of person who col	npleted cause of deeth (	(Item 23e) (Type		5 (DIS	consin	Λ.	7	ETP	mo.
	CA		31. Date filed (Month, Day, Year)	32. Radietarie 9	idhature •	0	0015	A1711	1 1200	3	Heigh	S
	Sta		JUL 0 1 19	31 Gilla D	avidson-40	mobile						

Registrar

State of Maryland / Department of Health and Mental Hygiene 97 211,92

		Certificate of Death Reg. No.										41476	
	Dhusia	ian	1. Decedent's Neme (First, Mide			)				2. Dete of Dea Month		Yeer	3. Time of Death
	Physic /Medi		WILLI	an 14.	LTUR					TUNE		1997	735 pM
	Exami		4e. Fecility Neme (If not institution Heartland Nurs			Riggs	Rd		wn, or Loc CtsVi	ation of Death		ty of Death	orges
	Funeral Director		5. Sociel Security Number 578-36-0093	6. Sex 7. A	ge (In yrs. lest b 87		If Under 1 Year Months Deys		24 Hrs. Min.	8. Date of Birth Month, Day May 2,	1910	9. Birthp New	place (State or Foreign Kent City V
	pu »		Usual Residence of Decedent  10a. State 10b. Count		10c. City, To		4:					1.	
	sho	5	DC DC. Count	,								1	0d. Inside City Limits 11√2 Yes 2 □ No
	28a-f	ect	10e. Street end Number		wası	hingt	10f. Zip Code				On Civinan of	11/h = 4 Co	21
	23e or	Funeral Director	5017 Hanna Pla	ice SE			2001	9			0g. Citizen of USA		ntry?
21215-0020	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mantal Hygiena. Item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Medical Exerciper must be notified at	by	11. Marital Status 1 □ Never Marrled 2 ☑ Ma 3 □ Widowed 4 □ Divorce	If Yes, Give	?	If Y	as Decedent of es, specify Cub	en, Mexicen	gin? (Spec , Puerto R	oify Yes or No- lican, etc.)	Ble	ice - Americ eck, White, ify: Bla	etc.
5-0	72 ho	Completed	15. Decede	nt's Education	16	e. Deceder	nt's Usual Occu	petion	of warkin		16b. Kind of E	3usiness/Inc	dustry
21	ithin nan	npie	Elementary/Secondary (0-12)	College (1-4or	5+)		nd of work done NOT use retire	ed)	OI WOIKIII	9	77.0		
	led w lygier ler th	S				Labor	er						inting Off:
Maryland	12 should be filed within hand Mantal Hygiene. I hand Mantal Hygiene. I he marked other than "raumatic event, the Mex	To Be	17. Father's Neme (First, Middle Moses Hilton	, Last)					rs Name cah M	(First, Middle, Maiden Sumeme) acon			
lan	s ma		19e. Informant's Neme/Reletion	ship (Type, Print)	19	b. Meiling	Address (Stree	t end Numbe	r or Rurel	Route Number	, City or Town	n, Stete, Zip	Code)
	1 and Health em 27		Sallie Jeter I	Hilton			Hanna P	lace S	SE Wa	shingto	on DC 2	:0019	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once.		20a. Method of Disposition 1 XBurial 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (		cemet	tery, creme	ion (Neme of tory or other ple 11 Ceme		7-	Date 20c. Location - City or Town, Stete 1–97 Suitland MD			
alti	mit.		21. Signeture of Funeral Service			22. 1							
) —	permi Depar Impor any Ir		> flexander	sope le.			-					. Was	h. DC 20020
			23a. Pert1. Enter the disease, of shock, or heart feilure. Lis	complications that cause tonly one cause on each li	d the death. Do	not enter	the mode of dyi	ing, such es	cardiac or	respiretory err	est,		Approximete Interval Between
	Physician /Medical		Immediate Ceuse (Final								Λ		Onset end Death
	Examiner		disease or condition resulting in deeth)	a ANTE	TR1050	class	OTIC	ANDIC	148	WIAN	Disa.	te	yan N
		<u>a</u>			Due to (or es e	e conseque	ence of):						
	ficata be axecuted physician and sthe burial-transit	Examiner		b	D		7 0						
ć	axecin and ial-tra	Exa	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury		Due to (or es e	e conseque	ince of):						
68760,	ra be ysicia e bur	cai	thet initieted events	С	Due to (or as e	conseque	nce of):						
	g phy as th	Medical	resulting In deeth) Lest		D 00 10 (01 03 0	conseque	1100 013.						
Box	leath certific attending pl	2		d									
	deat	Physician/	Pert II. Other significent conditi	one contributing to death b	ut not resulting	In the unde	erivina cause oi	ven in Pert I.		23b. Did to	bacco uea co	ontribute to	the cause of death?
P.0	the de	λή					,,						pably 4 dinknown
	es that igned be be det	by F	MMEMAC	Tryp End En	SON								
Vital Records,	requir been s should	Completed	SENIE DE	MENTIN						24a. Wes e perform	n eutopsy ned?	eva	ere eutopsy findings ailable prior to mpletion of cause deeth?
æ	The law ate has page 2	E O								1 D V	s 2BNo		Yes 2□ No
ta		Be C	25. Wes case referred to medica	1	***			26 Plece	of Deeth	(Check only on			1162 20140
>		To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2□ER/C	Outpatient	3 DOA Ot	-		e 5 🗆 Reside		her (Snecifi	v)
of	g Phys er this eral di		27. Manner of Death	28e. Date of Inju		Time of	28c. Inju			3d. Describe ho			//
Ö	Attending F ar death. ector: After by tha funer iffication:		1 ☑Natural 5 ☐ Pendi 2 ☐ Accident invest	gation (Month, De		Injury		rk? ]Yes 2∐N	No				
Division	il or Attending P safar death. I Director: After t d in by tha funera	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homlclde determ	not be One Diese of the	ury - At home, f	ferm, street	t, factory, office		28	Bf. Location (St City or Town	reet end Num n, Stete)	ber or Rura	l Route Number,
	oltal urs a val												
	To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in b	edicai	29a. Certifier 1 Certifyli (Check only 2 Medical one)	ng Phyeician: To the best Examiner: On the basis of end manner st	l exeminetion e	ge, deeth oo nd/or Inves	ccurred et the ti	me, dete end opinion, deeti	i piece, er h occurred	d due to the ca d et the time, d	ause(s) end m ate end piece,	enner es st , end due to	the cause(s)
	To the Within 2 To the comple	Σ	29b. Signature and title of certific		0		29c. Licens				9d. Dete signe		
	5		Junlas	Vectore 4	uX	23a) (Type Agint) 03 Cheensburg Rd Hyattrille MD 2078,							
	(10)		30. Name end eddress of person	who completed cause of d	leeth (Item 23a)	(Type Pci	nt) eensch	1/10 4	201	44677	frille	MA	20781
	Sta		31. Date filed (Month, Day, Year,		er's Signeture	al II	-704 3	J, 4 )		7 90			9, 210
	Registr	ar	JUN 301	331 July 10		-							

State of Maryland / Department of Health and Mental Hygiene 97

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			Certificate of Deat	th	Reg	. No.	41130							
	Physici	ian	Decedent's Neme (First, Middle, Last)		ete of Deeth	Dev Yaa	3. Time of Deeth							
	/Medi		Gloris L. Hearns	, Town, or Location		,								
	Examir	ner												
_		H	Prince George's Hospital Center Che  5. Sociel Security Number 6. Sax 7. Age (In yrs. last birthday) If Undar 1 Yaar If Undar	everly	ate of Birth	Prince	George's							
Ш	Funeral Director		266-72-7629 1□ M 2♀ F 59 Yrs. Months Deys Hour.	der 24 Hrs. 8. De rrs Min. (M	onth, Dey, Y /21/3	'ee <i>r</i> ) 9. 2 7 F	Birthplace (State or Foraign Country) Lorida							
Z Post	Mo w		10a. State 10b. County 10c. City, Town or Location				10d. Insida City Limits							
Z		ctor	Md. P.G. Landover				1⊈ Yes 2□ No							
ti with	23a or 28	ai Director	10e. Street end Number 7017 Kent Town Drive 10f. Zip Code 20785		10g	U.S.A.	•							
5-0020 72 hours after death with the Maryland	"natural", or frems 23a or 28a-4 show	by Funeral	11. Marital Status  1 □ Never Married  1 □ Never Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Evar in U,S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Yaar or Dates:  13. Wes Dacedent of Hispenic In If Yes, Specify Cuban, Mexical In Yes, Give Yaar or Dates:		es or No- , atc.)	14. Rece - Ar Black, Wi Specify:	merican Indian, hite, etc. Black							
Maryland 21215-0020	45	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16e. Decedent's Usual Occupation (Give kind of work done during m life. DO NOT use retired)			b. Kind of Busines								
9 5	d other than		12th Cosmetologist  17. Fathar's Name (First, Middla, Last)  18. Mo	othar's Nama (First		Cosmeto	oLogy							
and and and		To Be	Eddie Lee Gardner	•	a Odo	, and the second								
ary	th and Manta 7 is marked traumatic ev	-	19a. Informent's Name/Reletionship (Type, Print)  19b. Meiling Address (Street and Num		rel Route Number, City or Town, Steta, Zip Code)									
, Z	Haalth em 27 i		Herman L. Hearns/Husband Same as # 10	above										
Baltimore,	of He		20e. Method of Disposition  20b. Place of Disposition (Neme of cematary, cramatory or other place)  20c. Method of Disposition (Neme of cematary, cramatory or other place)	Det		c. Location - City								
tim	tant:		4 □ Donetion 5 □ Other (Specify) GIENWOOd Cem.	ash.,D.	С.									
Bal	Department of Health Important: if item 27 any injury or other ti		4 Donetion 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name end Addrass of Facility  H. S. Washington & Sons, inc. 4925 Burroughs Ave., N.E.											
		J	23a. Part1. Enter tha disease, or complications that caused the death. Do not enter tha mode of dying, such shock, or heart failure. List only one cause on each line.				Approximete Intervel Between							
1	hysician Medical xaminer		Immediate Cause (Final disease or condition				few days							
	Adminio.	-	disessa or condition resulting In deeth)  Due to (or es a consequence of):				few days few weeks for 3 years							
petr	ansit	Examiner	Sequentially list conditions,  Due to (or es e consequence of):				Jus 0 mgs							
ox 68760, certificate be executed	physician and s the burial-transit	Еха	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events				In ? Has							
68760, ficata be av	nysick he bu	edicai	Cause (Disease or Injury that initiated events resulting in deeth) Lest  Due to (or es a consequence of):				0 30 9							
x 68	.E 8	2	d											
Box auth certi	attand for us	lan/	<b>U</b> .											
P.O.	igned by tha atta be datached for	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pe	ert f. 2			rite to the cause of death?  Probably 4 Unknown							
Vital Records, P.O. Bo	s been sign 2 should be	Completed by		24	4a. Was en e perlorme		Were eutopsy findings available prior to completion of cause of death?							
	ata has paga 2	Com			1 Tes	2 0 No	1 ☐ Yes 2 ☐ No							
of Vita Physician:	artifica actor,	Be	examiner?	lece of Deeth (Che	ck only one)									
	this call dire	7	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐	Nursing Home 5		-	pecify)							
Division of or Attending Physics	death. Hor: After the funer	ation	27. Manner of Death  1 Noture   5 Pending   28e. Dete of Injury   28b. Tima of Injury		ascribe how	injury occurred								
Divis	within 24 hours aftar daath.  To the Funeral Director: Aftar this cartificata ha complataly fillad in by the funeral director, page	Certification:	3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)											
Hospi	within 24 hours afta To the Funeral Dir. complately filled in	edicai	29e. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deed on manner steted.	end plece, end du deeth occurred at to	e to the ceus he time, date	se(s) end menner end place, end d	es steted. ue to the ceuse(s)							
2		~	and the second s		004									
To the	within 2 To the compla		29b. Signetura and title of certifiar 29c. Licansa numbe	1 11	290.	Date signed (Mo	nth, Day, Year)							
To the	Toth		296. Signetura and title of certifiar  D 1 5 2  30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)  D Y JALAL Fatem 1 5 6 3 2 Ann a Polis R	_14	290.	S . 2	onth, Day, Year)							

DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene 0.7 211.01.

			Certificate of Death Reg. No.												
	Physic	an	1. Decedent's Name (First, Middle, Last)		2. Date of De Month	ath Day	Year 3	3. Time of Death							
	/Medi		Myrtle Lucille Johnson		July	1, 1	997 1	0:30 pm							
d	Exami	ner	4a. Facility Name (If not institution, give street and numbar)	4b. City, Town, or I											
			Bel Forest Nursing & Rehab. Center		st Hill		Harfo								
	Funeral Director		5. Social Security Number 219-58-3452    Usual Residence of Decedent   Control of the control of	faar If Undar 24 Hrs. Pays Hours Min.	8. Data of Bir (Month, Da Aug. 2	th y, Year) 5, 1922	9. Birthplace Country) Mary	a (State or Foreign Land							
	gand ow		10a. State 10b. County 10c. City, Town or Location				10d.	Insida City Limits							
	Mary First	to	Maryland Harford Bel Air				- 4	1X Yes 2 □ No							
	th the	Director	10e. Street and Number 10f. Zip Co	ode		10g. Citizen of V	/hat Country?	?							
	th will	al	705 Old Orchard Road	21014		US	SA								
20	permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Hauth and Mental Hyglena. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic avent, the Medical Examination contact.	by Funeral	1 Never Married 2 XMarried 1 Yas 2 X No If Yes, Give 1 Yes 2 X	t of Hispanic Orlgin? (S Cuban, Maxicen, Puart No Specify:	pecify Yas or No o Rican, etc.)	- 14. Race Blac Specify	- American I k, Whita, atc.								
٥ ٻ	tural	Pa	3 ☐ Wildowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual O	ecupation	-	16b. Kind of Bu									
21215-0020	I within 72 Iena. • than "na	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  4  Real Estate	lone during most of wor etired)		Real Es	state								
	e filed al Hygi other vent,	BeC	17. Father's Nama (First, Middle, Last)	18. Mothar's Nan											
ylaı	should be ind Mental in marked or umatic ave	To	Grover Cleveland Greer	Annie	Ethel	Osborne									
Maryland	2 short and is mu		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Malling Address (Single Carl Johnson – Husband  705 Old Ord												
	f and Haalth em 27 other tr				Date Date	20c. Location -		Ctoto							
non	Pages nent of t int: If ite iny or of		20a. Method of Disposition  1  Burial 2  Cremation 3  Ramoval from State 4  Donation 5  Other (Specify)	r place)	7-5-97	Bel Air									
altimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee 22 Name and A	ddress of Facility											
ä	Depa Impo any in		Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009												
		1317 Cokesbury Rd., Abingdon, MD 21009 23a.Part 1. Enfer the disease, or complications the ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest.  App													
	Physician /Medical	6 1	Onset and Death												
	Examiner		disease or condition resulting in death)  a. #/Zhe/mer's -//	re Dem	entin			years							
		ner	Due to (or as a consequence of):												
	ificate be executed g physician and as the bunal-transit	edical Examiner	Sequentially list conditions.  Due to (or as a consequence of):												
60,	be ex ician bunal	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.													
68760,	fficate p phys	<del>g</del>	that initiated events												
		M/	d												
E	daat ne att	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying ceus	a givan in Part I.	23b. Dld	tobacco uae con	tributa to the	e cause of death?							
P.O.	that the	by Phy			10	Yes 2000	3 Probabl	ly 4 Unknown							
Records,	The law requiras that the daath cer ate has been signed by the attendir page 2 should be detached for use	Completed b			24a. Was perfo	an autopsy med?	availat	autopsy findings bla prior to letion of ceuse oth?							
ř	hysician: The law nis certificate has b i director, page 2 s	EO			10	res 2 No	1 🗆 Ye	es 2 No							
Vital	clan: ertifica ector,	Be	25. Wes case referred to medical examiner?	26. Place of Dea	th (Check only o	nne)									
		5	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  27. Manner of Deeth   28a. Date of thiury   28b. Time of   28c.			dence 6 Othe									
0	ding in.	tion	Neturel 5 Pending (Month, Day Year) Injury	tnjury at Work? 1 ☐ Yas 2 ☐ No	28d. Describe i	now injury occurre	90								
DIVISION OF	il or Attanding Physician: after death. I Director: After this certific d in by tha funaral director.	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, of		28f. Location (S	Street and Number	er or Rural Ro	oute Number,							
ā	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	Certification:			City or Tov										
	Hosp 24 hou Fune stely fi	edical	29a. Certifier  (Check only one)  Amedicat Examiner: On the basis of examination and/or invastigation, in and manner stated.	ne time, dete end place, my opinion, daath occur	and due to the red at the time,	cause(s) and me date and place, a	nner es steted and due to tha	d. a ceuse(s)							
	vithin Fo the	M	29b. Signature and title of certifiar 29c. Licansa number 29d. Data signad (Month, Day, Year)												
			1 Meni la m.o. I	350/2		JULY	3,19	97							
,	10														
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  J. Kevin Lynch m.D. 2 Nort	L AVE.	Isel A	tir, M	1. 2	. 1017							
	Sta		31. Date filed (Month, Dey, Year) 1997												

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B.K.S			State of I	Maryland /	Departmen			and Me	ental Hy	giene 9	1	21495	5
TH DORET					Certifica	te of	Death			Reg. No.			
Physiciar		It's Name (First, Middle, I						2	2. Date of De Month	Day	Year	3. Time of Deat	
/Medica	1-0	IH D	JONES				4b 02b T		JUNE		97	2341P	M
Examine	4e. Fecility I – 9	Neme (If not institution, g 5 SOUTHBO	UND OF 8				Abel Abel			th 4c. County HARE			
Funeral			Sex 7	Age (In yrs. lest i	birthday) If Under	er 1 Year Days			B. Date of Bi	rth av Year)	9. Birthpl	ece (Stete or For	əign
Director		-32-4451	1□M 201F	64	Yrs.	Days	riouis	IVIII ).	(Month, De	19-32	Court	MD	
and **	10a. State	dence of Decedent 10b. County		10c. City, To	own or Location		·		-		10	d. Inside City Lin	nits
Ind 21215-0020  be filed within 72 hours effer death with the Maryland tell Hygiene. I other than "natural", or Nems 23s or 28s-f show avent, the Medical Examiner must be notified at the Completed by European Disease.	MI	HARI	FORD	1	BERDER	< N						Yes 2	
vith the Mar	10e. Street	end Number				ip Code				10g. Citizen of V	Vhet Coun	ry?	
13a o		PLAXA (	CT. AY	T. 3A		21	1001			11.5	A		
r Items 23th	11. Marital	Status	12. Wes Deceder Armed Force	nt Ever in U,S.	13. Was Dece If Yes, spi	adent of h	lispanic Orig	gin? (Spec	ify Yes or No	0- 14. Rac	a - America k, White, e		
or ft		er Merried 2 Married	1 ☐ Yes 2	No.	1 □ Yes	01	Specify:	, , , , , , , , , , , , , , , , , , , ,	iouri, 010.)	Specify	77 1	2 K	
"natural", or		lowed 4 Divorced	Year or Date								0111		
ed within 72 ho ygiene. Per than "natur It, The Medical		15. Decedent's (Specify only highest g	Education rede completed)	16	Sa. Decedent's Usi (Give kind of w life. DO NOT I	ork done	during most	of working	7	16b. Kind of Bu	isiness/Ind	ustry	
Hygiene. ther than	Elementa	ry/Secondary (0-12)	College (1-4c	or 5+)	Adminis		,	lerk		Cival	Servi	ce	
should be filed within and Mentel Hygiene. marked other than umatic avent, the March Comp.		Name (First, Middle, Las	st) /				18. Mothe	r's Name (	First, Middle	, <i>Maiden Surn</i> em	Θ)		
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Health lem 27 i	My	PON JONE	55	1	303 PLA	ZA (	CT. A.	PT31	H H	GERDEL	d, M	d. 2100	2/
nent of H int: If iten iry or oth	20a. Metho	d of Disposition riel 2 ACremation 3	☐Removel from Ste	ceme	of Disposition (Ne tery, cremetory or	other ple	-0	1	Dete	20c. Location -		444	
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10.2 % 0	6	Enter the disease, or co	1 /m/	81	552	Leu	0,5 5	- + H	ovre	de G	race	ame	
Physician	shock	, or heart failure. List on	y one cause on each	line.			9, 555, 25		, copilatory a			Approximate Intervel Between Onset end Death	
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should should									perl	ormed?	cor	ilable prior to opletion of cause	
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irecto n by ti	3 ☐ Sui		28e. Plece of building,	njury - At home, etc. (Specify)	farm, street, facto	ry, office		28	City or To	(Street and Numb			07
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s ⊨ ō	•	M	>				C.M.E	E		JUNE			
V	30. Name	nd address of person who	completed cause of	deeth (Item 23e	) (Type, Print)								
0		Amo X-	N		Penn S	tre	et, E	Balti	imore	, Marv	Land	21201	
State	31. Dete file	(Month, Day, Year)	32. Regis	strer's Signature	0		•						
Registrar		HINLOG 10	107	A STATE OF THE PARTY OF	BALL								

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21496 Certificate of Death 2. Dete of Death 3. Time of Death **Physician** Marion 833 PM JUNE /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 4b. City, Town, or Ab. City, Town, or Ab. City, Town, or Ab. City, Town, Or Ab. City, Town, Dev. Min. 8, Date of Birth Month, Dev. RFORO HARFORD Age (In yrs. last birthday) Yrs. 5. Social Security Number 9. Birthplece (Stete or Foreign Country) Pergl A **Funeral** 1□ M 2 EF 218-34 Months Deys Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at HARFORI Yes 2□No Director berdeen 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 21001 U.5A Funeral 12. Was Decedent Ever in U,S. Armed Forces?, 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indien, Bleck, White, etc. 11 Marital Status Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes No Specify: Baltimore, Maryland 21215-0020 ò Black 3 Widowed 4 □ Divorced 'natural'. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retire#) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Donestie Housekeepinc permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien important: if Item 27 is marked other the any Injury or other tremment. 10 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Lizzie Marion UNK PReston 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cametery, cremetory, or other place) berdeen, MD 21001 JIMW/Lee SONES 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Aberdeen 4 Donation 5 Other (Spegify) Funeral Seg Approximate Interval Between Onset end Deeth ewi5 23a. Part 1. Enter the disease, or complications that are sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediete Ceuse (Final diseese or condition resulting in death) **Examiner** 2 day Physician/Medical Examiner the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Lest 98 attending a Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 No 3 Probably 4 □ Unknown Be Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? certificete 2 NO 1 Yes 20 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? To the Hospital or Attanding Pt within 24 hours effer death. To the Funeral Director: After th completely filled in by the funera 28d. Describe how injury occurred After 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined PICable Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, far building, etc. (Specify) 4 ☐ Homicide

of Vital Division

Nettie Marion Jone

0055

State Registrar 29a, Certifier

29b. Signature end title of care

31. Date filed (Month, Day, Year)

JUN 2 6 1997

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

11.

Q.

Certifying Physicien: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end manner es steted.

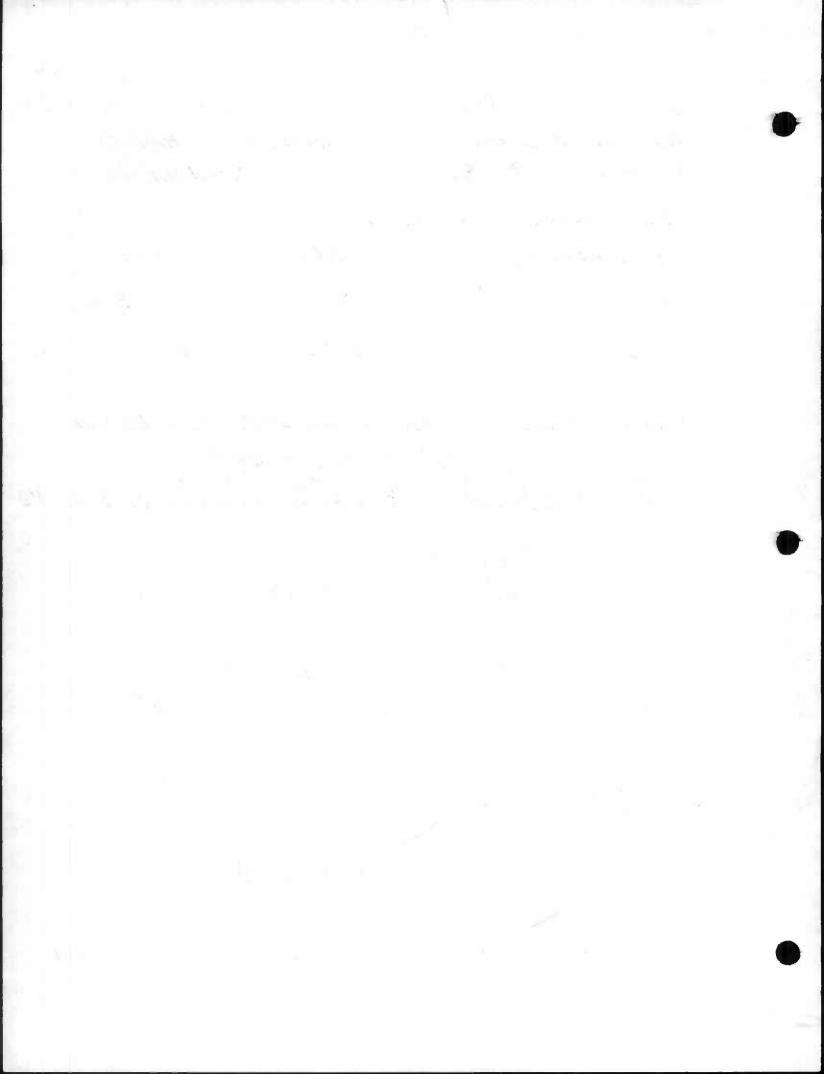
2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and menner stated.

29c. License number

D1958

29d. Date signed (Month, Dey, Year)

2100 M



State of Maryland / Department of Health and Mental Hygiene

21497

						Ce	rtificate of	Death		Re	g. No.				
п			1. Decadent's Name (First, Min	ddle, Last)						2. Date of Death	h Day	. 27 4	3. Time of	f Death	
Physi			Colored D				1	Tmal	,	Month	Year	10.			
	/Medi		4a. Facility Name (If not institu	tion give street and nu	mharl -		JEI	Ab City To	wn orte	ocation of Deeth	40 5000	997	10.	03 A	
	Exami	ner										y of Deeth			
				ON ADVENTIS				TAKOM			N	IONTGC			
	Funeral		5. Social Security Number	6. Sex 1  M 2	7. Age (In yrs. last		Months Days		24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpi	iace (State o	or Foreign	
н	Director		578-26-0241	ILIM ZULF	72	Yrs.	and and	710010		JULY 3,	1924	MINN	ESOTA	1 119	
	D	1	Usual Residence of Decadent												
	ylar Mow		10a. State 10b. Cour	nty	10c. City, T	own or Lo	ocation					10	0d. Inside Ci	ity Limits	
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	ith the Merylar or 28a-f show or notified at	Director	10e. Street end Number	2102 020102		20020	10f. Zip Code			10	og. Citizen of	Minet Cours	en «O		
	With Page 1							•		10	y. Citizen of	WHAT COUR	Iry r		
	ath w	<u>a</u>	2300 SEMI	VOLE ST.			20	0783			U	J.S.A.			
	be filed within 72 hours effer death with the Meryland tel Hygiene. Id other than "natural", or items 23s or 28s-f show event, the Mexical Expriner must be notified at	Funeral	11. Maritai Status	12. Was Dece	edent Ever in U,S. prces?	13.	Was Decedent of If Yes, specify Cu	Hispanic Orl ban, Mexicar	lgin? (Sp	ecify Yes or No- Rican, etc.)		ce - America			
0	or it	正	1 ☐ Never Married 2M M	arried 1 ☐ Yes	2 00 No		1 □ Yes 2 X No						7(6.		
21215-0020	ours Eres	by	3 ☐ Widowed 4 ☐ Divord	ed Year or D	ates:		ILIYES ZUALNO	Specify:			Specif	y: WH	TTE		
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ar	0 0 0		19a. Informant's Name/Relation	nship (Type, Print)	1	9b. Mailir	ng Address (Stree	at and Numbe	a <i>r or R</i> un	al Route Number,	City or Town	, State, Zip	Code)		
	27 Part		EMIL F. JE	ETTMAR/HUSB	AND	SAME	AS I	TEM #	10						
ā,	of Heel		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of			Date 2	Oc. Location	eation - City or Town, Stete			
2	Peges net of int: If its iry or o		1 ☐ Burial 2 🛣 Crematio		State came	etery, crer	matory or other pl	aca)	1			o., o	, 0.0.0		
Baltimore,			4 □ Donation 5 □ Other	(Specify)	CHAN	MBERS	CREMATO	DRY		7/1/97	RIVER	DALE,	MD.		
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	thet the ed by th detechs		Seveni	men	na					1□ Ye	2 No	3 Prob	abiy 4 🗆	Unknown	
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Ę	Physician: this certific ral director,	Be	25. Was case rafarred to medic examiner?						of Death	(Chack only one	)				
=	5 00	2	1 ☐ Yas AN No	Hospital:	patient 2 ER/0	Outpatien	t 3□ DOA O	her: 4□ Nu	rsing Ho	me 5 🗆 Resider	nca 6 Oth	ner (Specify)	)		
5			27. Manpar of Death	28a. Data o	of Injury 285	. Time of	28c. Inju	iry at	:	28d. Describe how	v Injury occur	red			
ō	ath. : After e fune	te l	2 Accident investigation  2 Accident investigation  3 Suicide 6 Could not be  28e Place of Injury - At home farm street, factory office.												
15	or Attending effer deeth. Director: Aftel in by the fune	f C								her or Burel	Route Num	her			
Division of Vital Records,	or A effer Direct	포	4 Homicide	buildin	ng, etc. (Specify)	varrit, oti	out, leatery, allies			City or Town,	State)	, o. o. riaia	710010 710111	001,	
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	tose une	edicai	29a. Certifier 1. Certify (Check only 2 Medical	ring Physicien: To the la il Examiner: On the ba	best of my knowled	ge, death	occurred at the ti	me, data en	d place, a	and due to the cau	use(s) and ma	anner as sta	itad.	,	
	To the Hospital or Attentwithin 24 hours effer deet To the Funeral Director: completely filled in by the	8	one)	and mann	er stated.	actor of 1119	outgation, arrily	opinion, deal	iii oocuiii	ou at the time, dat	e and place,	anu due to	ure cause(s)	1	
	To t	Σ	29b. Signature and title of certif	ier .			29c. Licen	se number		29	d. Date signe	d (Month, D	lay, Year)		
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			12AJ MACHUN	WA	tshugton	И	Helver	TUJT	- 1	الما الما	-,11	1/1014	11 /17	1 M	
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State Registrar

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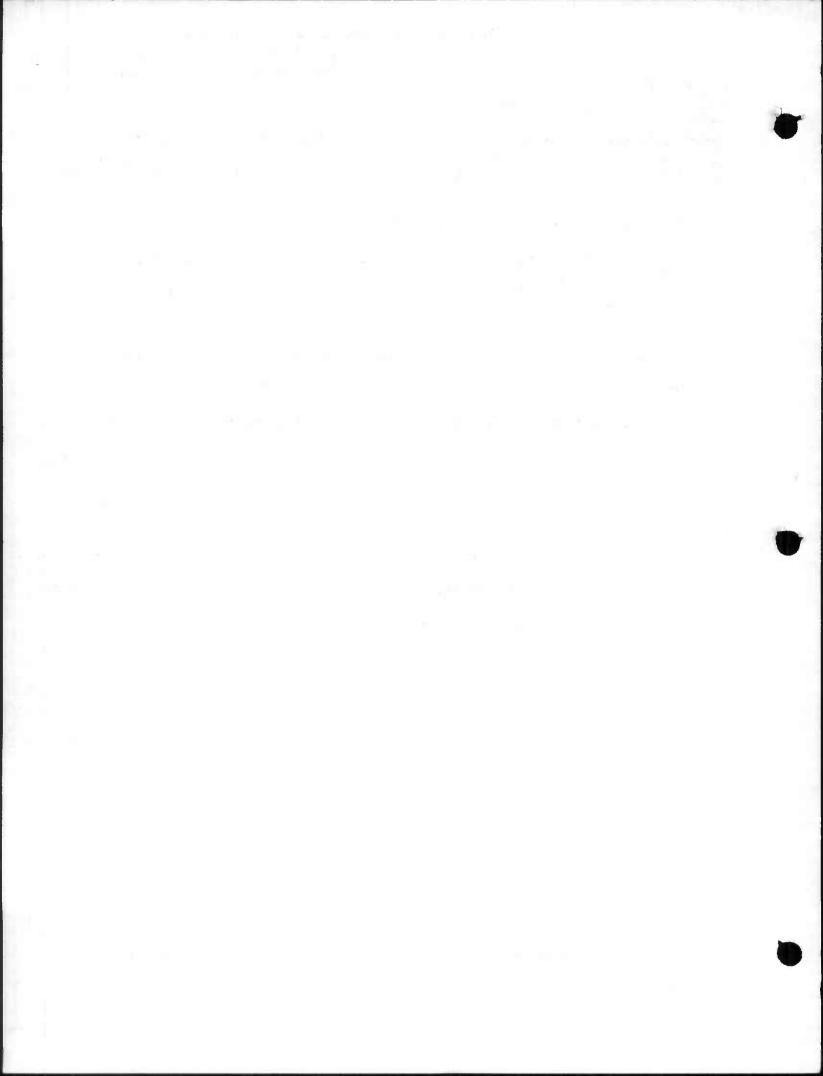
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	0.00	H	1. Decedent's Name (First, Midd	lle, Last)							2. Dete of De	eth		3. Time	of Death	
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3	/Medic Examir		4e. Fecility Name (If not institution						4b. City, To		cation of Deeth		ty of Death	3.1.	TALL	
	Examir	ier	15100 Interlac			1020			Silve				gomer	**		
Н			5. Sociel Security Number	6. Sex	7. Age (In yrs.		If Under	1 Year		24 Hrs.	0		-	_		
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	dand w		10e. State 10b. Count	у	10c. Ci	ty, Town or L	ocation						1	IOd. Inside (	City Limits	
	the Mary 28a-f sh	rector	MD Montg	omery	Sil	ver Sp	ring	Code				10g. Citizen o	Mhat Cour		s 211 No	
	filed within 72 hours efter death with the Maryland Hygiene. ther than "natural", or ferms 23a or 28a-f show out, the Medical Examiner must be notified at	by Funeral Director	15100 Interlac			- T		20	906			USA				
	er de	nu	11. Marital Status	Armed Fo		J,S. 13.	If Yes, spec	dent of cify Cul	Hispanic Ori oen, Mexicai	igin? (Sp∈ n, Puerto	ecify Yes or No- Rican, etc.)		ace - Americack, White,			
0000	ours eft	1 by F	1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes Giv	re T		1 ☐ Yes	2 🔼 No	Specify:			Spec	ity: W	hite		
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours efter dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any Injury or other traumatic event, the Medical Examiner is any Europe.	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grede completed) College (1	-4or 5+)	(Give	16e. Decedent's Usuel Occupation (Give kind of work done during most of work life. DO NOT use retired)  Business Office Manage:			st of worki	ing	16b. Kind of	f Business/Industry			
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lar	id be lenta ked ic ev	To B	Rudolph E. Stromberg Anna LeDan							Dane						
Maryland	shou mer	-	19e. Informent's Neme/Relation			19b. Mail	ing Address	(Stree			al Route Numbe	er, City or Tow	n, State, Zit	Code)		
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Bal	Deper impor any In		21. Signeture Funeral Service Licensee    22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901													
	Physician		23a. Pert1. Enter the disease, o shock, or heert failure. Lis	r complications that c t only one cause on a	aused the dear ech line.							rest,		Approxima Intervel Be Onset end	etween	
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	Examiner		disease or condition resulting in death)	e. 00F	せん・シ			.c.	200	MI				5 mes	127	
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Vital		Be (	25. Wes case referred to medica	al.					26. Place	of Death	(Check only o	ne)				
>	Physician: this certific ral director,	To	examiner? 1 ☐ Yes 2 No	Hospital:	npatient 2	ER/Outpetie	nt 3□ DC	A Ot	her:	ursing Hor	. /	lence 6 🗆 O	ther (Specif	v)		
of	g Ph er th		27. Manner of Death	28a. Dete	of Injury h, Day Year)	28b. Time o		8c. Inju			28d. Describe h			,,		
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Frank C. Blackburn, M.D., 5401 Western Avenue, NW, Washington, D.C. 20015								nue. NW. Wa	shinaton	. D.C.	2001	5			

State Registrar



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